| | | | DIVISION OF | VITAL RECORDS, 30) W. PRESTO 11m #G388 4/25/67 P | ON STREET, BALTIMO | RE, MARYLAND 21201 | |
|---|--|---------------|--|---|-----------------------------------|-------------------------------------|--|
| FOR ST | ATE | | Otopo Item #9 F | MEDICAL EXAMINER'S | CERTIFICATE OF | F DEATH 05 | 278 |
| HEALTH D | | 1 5 | LACE OF DEATH | | I 2 USUAL RESIDENCE (W | here deceased lived, if institution | Residence before admission) |
| | 6% | | COLINTY | ********* | O. STATE | b. COUNTY | |
| ay is 3 to Page | THE STATE OF THE S | - | MONTGOMERY CITY OR TOWN (If outside corporate limits, | MARYLANO E LENGTH OF STAY IN 16 | MARYL | Side corporote limits, write RURAL | MONTGOMERY |
| y del and PM3. | A I | | write RURAL and give nearest town) | | | | ond give neorest rowny |
| 2 × 4 | por | | SILVER SPRINGS NAME OF HOSPITAL OR INSTITUTION (If not in | DO.A | ROCKV | 11-1-E | e. IS RESIDENCE |
| =- = | D An | | | | | | ON A FARM? |
| th iges in fa | State Depar | 3. 1 | HOLY CROSS HOSPITA | Middle | | N HILL ROAD 4 DATE Month | YES NO X |
| after death. If 8. Give Pages 1, alang with farm | 6 5 | 1 | ECEASED | | Lost | OF | Doy Year |
| after 8. Give | and 2 with the death | 5. 5 | ype or print) STANTE 6. COLOR OR RACE 7. | | CKERMAN B. OATE OF BIRTH | DEATH APRI | FUNDER I YEAR IF UNDER 24 HRS |
| | The state of | | 7, | | | lest builtiday) A | Aonths Doys Hours Min. |
| 24 haurs in Item 11 | death death | 100 | MALE CAUC USUAL OCCUPATION (Give kind of work done | 10b. KIND OF BUSINESS OR | JAN 27, 1934 | r foreign country) | 12 CITIZEN OF WHAT |
| | - 6 | durin | g most of working life, even if retired) | INOUSTRY | , | 3 | COUNTRY? |
| l in er's | off of | 13 | US NAVY FATHER'S NAME | | COZAD NEB | R. | USA |
| within 2 n pencil i Examiner | ile pag haurs | 10. | | | | | |
| Exa | File 2 hau | -15 | JOHN R. ACKERMAN WAS DECEASED EVER IN U.S. ARMED FORCES? | I 16. SOCIAL SECURITY NO. 17. | INFORMANT | HALVERSTADT | |
| of te | permit. Fi | (Yes | , na, ar unknown) (If yes give war or dejes at se | rvice) | | | EN HILL ROAD |
| e executer pending" of Medical | permit within | | TES PETION VILTY 18. CAUSE OF DEATH (Enter only one couse p | | RIANNE T. ACK | ERMAN ROCKVILLE | INTERVAL BETWEEN |
| "pen "pen | sit v | | PART I DEATH WAS CAUSED BY: | Myocardial Infar | ction. Acute | | ONSET ANO DEATH |
| | burial-transit n any event | | IMMEDIATE CAUSE (o). | ry ocaratat Intar | coton, | | |
| ward ward the Cl | urial. any | | Conditions, if ony, which gove) (b) | | | | |
| the st | | | rise to immediate couse (a), DUE TO | | | | |
| ng Jed | as a and i | | lost. (c) | | | | |
| s certificate shauld s, writing the ward farwarded ta the C | | | PART II. OTHER SIGNIFICANT CONDITIONS CONT | RIBUTING TO DEATH BUT NOT RELATED TO | THE TERMINAL OISEASE CON | DITION GIVEN IN PART I(a) | 19. WAS AUTOPSY PERFORMED? |
| 0 | be used removal, | CERTIFICATION | | | | | YES Y NO |
| This ficate, be fo | remi | THIC | 200. EXTERNAL CAUSE WAS | 20b, DESCRIBE HOW INJURY OCCURREO. | (Enter noture of injury in P | ort I or Port II of item 18.) | |
| | 3 shauld tian, or r | | PRIMARY or CONTRIBUTING CAUSE OF DEATH | | | | , |
| MINER: the cert 4 shauld or files. | | MEDICAL | 20c. TIME OF INJURY Month, Ooy, Year | | CE OF INJURY (Home, form, | 20f. (City or town) | (County) (State) |
| A the e the e de | Page cremo | ME | Hour o.m. p.m. 19 | While Not While of work | tary, street, office bldg., etc.) | | |
| EXA scute Page | , cr | | 21. I certify that I taak charge a | f the remains described above, he | eld an Autopsy 🗙, | Inspection X, Inquiry | and in my opinia |
| ex d | ECTO burial | | | | cide Hamicide | Undetermined man | The state of the s |
| Mease please director | n Pi | | | | CHIEF MEDICAL E | XAMINER | |
| | L DIR | | ACTUAL SIGNATURE SOMM5 | Bell | TIVED, | CAL EXAMINER | 22. DATE SIGNED |
| SSary, funeral | | | EXAMINER'S | | | EXAMINER X 4/1 | 6/67 |
| | O FUNERA Health pri | | NAME (Type) JOHN G.BALL MI |) | | thy, town, or tourny) | |
| nece the | He | 230 | RURIAL, CREMATION, 23b. DATE THERES | 967 23c. NAME OF CEMETERY OR | CREMATORY | 23d LOCATION (City or Town) | (County) (Stote) |
| _ | - | 15 | CHALDAL DIRECTION | | | BY REGISTRAR 25b. REGIS | TRAR'S SIGNATURE |
| VR A15 | | 24. | FJ.W. CHAMBER | s Co - WASHINETS | DC. DATE ! DI | 0.00 | Cincles Judge |

MARYLAND STATE DEPARTMENT OF HEALTH

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Sile (13/2001), Mileteration,

ON LIVE SHOW

. IS RESIDENCE ON A FARM? YES NO P

0527

(State)

INTERVAL BETWEEN

PERFORMED? NO [

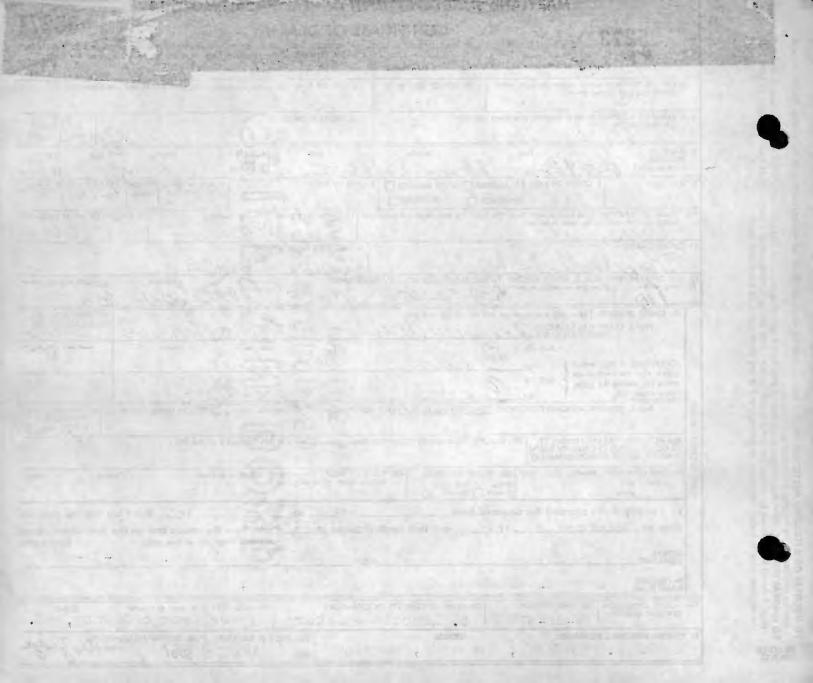
21. I certify that I attended the deceased fram Juky 1948, to 24 Mpril , 1967, that I last saw the deceased 1967, and that death accurred at 703 P.M. from the causes and an the date stated above.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Prince George County, Md.

PUMPHREY, Bethesda, Maryland

246. REGISTRAR'S SIGNATURE Jus



| | | | 05 | 272 | 1 |
|---------------------|--|---|---|---|--|
| | o STATE | | ed, if institution: b. COUNTY | | are admission |
| | | | its, write RURAL | and give neare | est town) |
| 4 days | Rolli | ing Hill | s Estat | es | 4313 |
| reet address) | | Willow | Mood | | e. IS RESIDENCE ON A FARM? YES NO |
| Middle | Last | 4. DATE | Month | Do | |
| S. AL | LBRITTON | OF DEATH | April | . 3 | 1967 |
| DIVORCED Ma | y 5, 1914 | lost 5 | (In years I birthdoy) M 2 yrs. | IF UNDER 1 YEAR | |
| BUSINESS OR | 11. BIRTHPLACE (County | & State, or fareign o | ountry) | 12. CITIZEN C | OF WHAT |
| | Arcadia, | Florida | | | USA |
| | | AME | | | |
| | F TERMINAL DISEASE FON | DITION GIVEN IN I | PART I(a) | 1 15 | 9. WAS AUTOPSY PERFORMED? |
| | | | | | YES NO |
| | | | | | |
| Not While at work [| y, street, affice bldg., etc.) | | | | (State) |
| the deceased from M | arch 30 , 1 | 9_67, to A | pril 3 m couses on | , 19 <u>_67</u> and on the do | that (d) (we) last |
| | | | | April | GNED 1967 |
| MD. | PHYS. | MED. DIRECTOR | STAFF PHYS. | Apr11 | 1, 2,01 |
| | | DIRECTOR L | | | |
| - | PHYS. 22d. ADDRESS Naval Hosp EMATORY [ational | pital, B | | Maryl) (Coun | and ty) (Stote) |
| FR III | MARYLAND LENGTH OF STAY IN 16 4 days treet address) Middle S. AL NEVER MARRIED B. DIVORCED Ma F BUSINESS OR RY ATH BUT NOT RELATED TO TH WE HOW INJURY OCCURRED. (E- OCCURRED Not While at work Coccurred at work | MARYLAND LENGTH OF STAY IN 16 4 days Treet address) Middle S. ALLBRITTON NEVER MARRIED DIVORCED May 5. 1914 F BUSINESS OR RY Arcadia. 14. MOTHER'S MAIDEN N Unknown L SECURITY NO. 17. INFORMANT ROllin Mrs. Tolona All (b), and (c).) neumonia ATH BUT NOT RELATED TO THE TERMINAL DISEASE CON THE HOW INJURY OCCURRED. (Enter nature of injury in Factory, street, affice bidg., etc.) TOCCURRED NOT While at work The deceased from March 30. | MARYLAND 2. USUAL RESIDENCE (Where deceased live of STATE California C. CITY OR TOWN (If autside carporate lim Rolling Hill.) 4 days Treet address) ALLERITION Middle S. ALLERITION NEVER MARRIED DIVORCED May 5, 1914 F BUSINESS OR RY Arcadia Florida 14. MOTHER'S MAIDEN NAME Unknown L. SECURITY NO. 17. INFORMANT Rolling Hills Mrs. Tolona Allbritton (b), and (c).) neumonia ATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN INCOMPANY F HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of at work OCCURRED OCCURRED | ARYLAND ARYLAND California C. CITY OR TOWN (If autside carparate limits, write RURAL ROLLing Hills Estat Rolling Hills Estat Rolling Hills Estat ALLBRITTON Middle Last ALLBRITTON B. DATE OF BIRTH DIVORCED DIVORCED DIVORCED DIVORCED ARY Arcadia Florida 14. MOTHER'S MAIDEN NAME Unknown L SECURITY NO. 17. INFORMANT Rolling Hills Estat Mrs. Tolona Allbritton, 5256 (b), and (c).) The umonia ATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) THE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) TOCCURRED NOT While at work The deceased from March 30 , 19 67, to April 3 | ALLBRITTON B. DATE OF BIRTH DIVORCED AT MOTHER'S MAIDEN NAME Unknown LISECURITY NO. 17. INFORMANT ROLLing Hills Estates, Calmonia 14. MOTHER'S MAIDEN NAME Unknown LISECURITY NO. 17. INFORMANT ROLLing Hills Estates, Calmonia 14. MOTHER'S MAIDEN NAME Unknown LISECURITY NO. 17. INFORMANT ROLLing Hills Estates, Calmonia ALLBRITTON DEATH Arcadia Florida 14. MOTHER'S MAIDEN NAME Unknown LISECURITY NO. 17. INFORMANT ROLLing Hills Estates, Calmonia Mrs. Tolona Allbritton, 5256 Willow Of Mother's Maiden Name Unknown ATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 15. CCCURRED NOW Millie of County, Street, affice bldg, etc.) 16. OCCURRED on PLACE OF INJURY (Hame, farm, factory, street, affice bldg, etc.) 17. OCCURRED on the decessed from March 30 , 19 67, to April 3 , 19 67, 19 67, and that death accurred at 1250 March motouses and on the decessed from March 30 , 19 67, to April 3 , 19 67, and that death accurred at 1250 March motouses and on the decessed from March 30 , 19 67, to April 3 , 19 67, and that death accurred at 1250 March motouses and on the decessed from March 30 , 19 67, to April 3 , 19 67, and that death accurred at 1250 March motouses and on the decessed from March 30 , 19 67, for April 3 , 19 67, and that death accurred at 1250 March motouses and on the decessed from March 30 , 19 67, for April 3 , 19 67, and that death accurred at 1250 March motouses and an the decessed from March 30 , 19 67, for April 3 , 19 67, and that death accurred at 1250 March motouses and an the december of the decessed from March 30 , 19 67, for April 3 , 19 67, and that death accurred at 1250 March motouses and an the december of the decessed from March 30 , 19 67, for April 3 , 19 67, and that death accurred at 1250 March motouses and an the december of |

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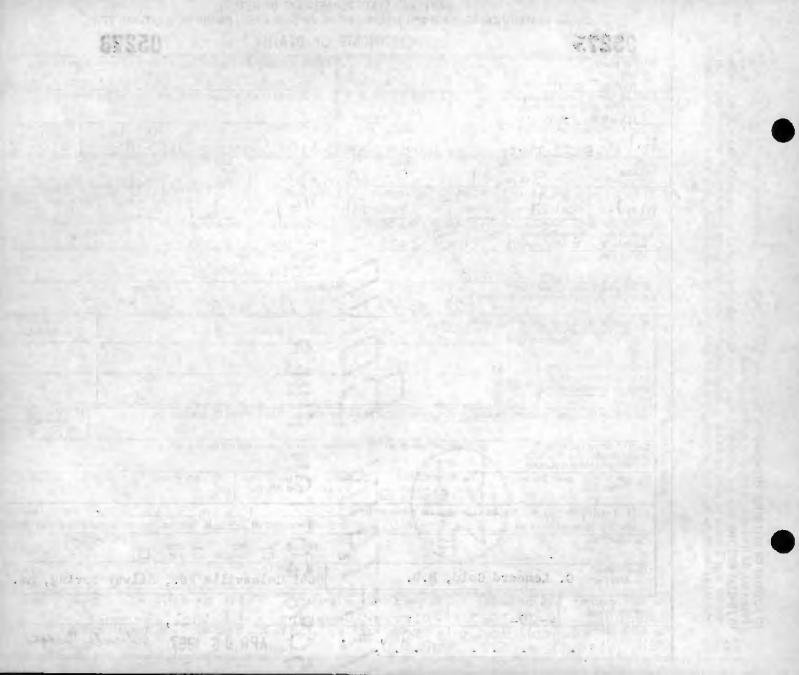
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05275 CERTIFICATE OF DEATH ond 2 deoth. 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission). PLACE OF DEATH o. COUNTY a. STATE the attending physician and completely filled in by the fur sit permit. Then please remove carbon papers. Pages 1 ve carbon popers. Pages 1 MONTGOMERY MARYLAND PHYSICIAN: The law requires that the death certificate be executed within 24 hours after b. CITY OR TOWN (If outside carparate linus c. LENGTH OF STAY IN 16 c. CITY OR TOWN (II autside corporate limits, write RURAL and give nearest tawn) write RURAL and give nearest town Uer e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS 105 2100 onnectico YES NO W DATE NAME OF Middle Year Last Day DECEASED 6 24 (Type or print) 0 DEATH 19 YEAR (In years birthday) IF UNDER IF UNDER 24 HRS. SEX B. DATE OF BIRTH AGE 6. COLOR OR RACE 7. MARRIED NEVER MARRIED lost Manths Haurs Davs inony WIDOWFD DIVORCED 100. USUAL OCCUPATION (Give kind of work done KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & Stote, or foreign country) during most of working life, even if retired) COUNTRY 3 INDUSTRY and PARKING 65 WASHINGTON, D.C. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME or removoi. ECRISTINA 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO INFORMANT Address (Yes, no, ar unknown) (If yes give wor or dotes of service) cremotion, INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) burial-tronsit PART I. DEATH WAS CAUSED BY Adenteception one IMMEDIATE CAUSE (o) signed by physician. DUE TO buriol Canditians, if any, which gave rise to immediate couse (a), DUE TO stoting the underlying couse os the Page 4 may be retained by the hospital or ottending O FUNERAL DIRECTOR: After this certificate hos been prior to lost. 19. WAS AUTOPSY PERFORMED? PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) detached for use NO. YES 205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port 1 or Port 11 of item 1B.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER (State) 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Hame, farm, (City or town) (County) 20c. TIME OF INJURY Month, Doy, Year factory, street, alfice bldg., etc.) at work 21. I certify that (1) (this haspital) attended the deceased fram_/stacy , 1966, to 4/24 . 1962, that (I) (we) last 1967, and that death accurred at 300AM, from causes and an the date stated above saw the deceased alive an 220. SIGNATURE 22b. DATE SIGNED **ATTENDING** STAFF PHYS. DIRECTOR eccado M.D. PHYS director, poge should be filed 22d. ADDRESS 22c. PHYSICIAN'S G. Lennard Gold, M.D. 8641 Colesville Rd., Silver Spring, Md. NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION, 23h DATE THEREOF (County) (State) REMOVAL (Specify) Fairview Cemetery Bethel Vermont 24. FUNERAL DIRECTOR Joseph 25a. REC'D BY REGISTRAR 2Sb. Gawl 3 VR A15 (4) 20 M 1/66 Wisc. Ave.



er Seath

MARYLAND STATE DEPARTMENT OF HEALTH

| | | DIVISION | OF VITAL I | RECORDS, 301 W. P | RESTO | ON STREET, BALTIMO | DRE, MAI | RYLAND 21201 | | | | |
|---------------|---|--|---------------------------|------------------------|--------|---|--------------|------------------------|-------------|------------|----------------------------|---------------|
| | 0527 | 6 | | CERTIFIC | CATE | OF DEATH | | 053 | 74 | | | |
| | PLACE OF DEATH | | | | | 2. USUAL RESIDENCE (V | Where dece | | | ce befor | e odmissio | n) |
| | o. COUNTY | ntgomery | | MARYLA | ND | o. STATE Virgi | w4 - | b. COU | YTY | | -20 | |
| | LETTY OF TOWN | If outside cornarate limit | \$, | c. LENGTH OF STAY IN | ., | c. CITY OR TOWN (IF ou | tside corpo | rote limits, write RUI | RAL ond giv | е пеогез | t town) | |
| | Pot hes | d give neorest town) | | 1 Day | | fi . | | | r | 10.2 | | |
| | | IAL OR INSTITUTION (If n | ot in hospital, | give street address) | | Norfo |) LK | | 3 | 3 0 | e. IS RESID | |
| | | Hospital | , , | , | | 9632 Atla | ns St | treet | | | YES T | ARM? NO KX |
| | NAME OF | F | rst | Middle | | Lost | 4. DATE | | h | Doy | | |
| | DECEASED (Type or print) | Kenne | th | McArthur | | Andrews Jr. | OF DEATI | H An | ril | 0 | 19 | 67 |
| - | SEX | 6. COLOR OR RACE | 7. MARRIED | | [K] | 8. DATE OF BIRTH | | 9. AGE (In years | IF UNDER | | IF UNDER | |
| | Male | Cauc. | WIDOWED | DIVORCED | | oril 11,1967 | . | lost birthdoy) | Months | Doys 18 | Hours | Min. |
| | USUAL OCCUPATION | N (Give kind of work done | | IND OF BUSINESS OR | LUSA | 11. BIRTHPLACE (County | | | | TIZEN OF | | 1 |
| dur | ing most of working | life, even if retired) | | NDUSTRY | | Portsmouth | T74 | ad mad n | CO | UNTRY? | ISA | |
| 13. | FATHER'S NAME | | | | | 14. MOTHER'S MAIDEN I | NAME | STHIR | | | SA | |
| | Kannat | th McArthur | A-2 | 1.4.4 | | Canalana T | | 70.00 | | | | |
| 15. | WAS DECEASED EVE | R IN U.S. ARMED FORCES? | 16 | SOCIAL SECURITY NO. | 17 | Sandra I | eign | Brown Addre | 255 | | | - |
| (Ye | s, no, or unknown) | (If yes give wor or dates | of service) | | | | | 9632 At 1 | | tree | t | |
| | NO CAUSE OF D | EATH (Enter only one co | an an Eas fa | (a) (b) and (b) | I_Ke | nneth M.And | rews | Norfolk, | Va. | DATE | ERVAL BET | SAFEFAL |
| | PART I. DEA | TH WAS CAUSED BY: | 0 | ONGENITAL H | ם אים | TOTOTA CT | | | | | SET AND D | |
| | 754 | IMMEDIATE CAUSE | (4) | ONGENTIAL D | EMIN | I DISEASE | | | | | | |
| | Conditions, if ony | DOL | | | | | | | | | | |
| | rise to immediat | le couse (o), | (b) | | | | | | | - | | |
| | stoting the unde | rlying couse | | | | | | | | | | |
| | last. | , | (c) | | | | | | | Lin | WAS ADE | o Desi |
| CATION | PART II. OTHER SI | IGNIFICANT CONDITIONS C | ONTRIBUTING | TO DEATH BUT NOT RELAT | ED 10 | THE TERMINAL DISEASE COM | IDITION GIV | /EN IN PART 1(0) | | | WAS AUTO PERFORMI ES | |
| CERTIFICATION | 20o. ACCIDENT WA OR CONTRIBUTING (IF EITHER, NOTIFY | S UNDERLYING CAUSE OF DEATH MEDICAL EXAMINER) | 20b. D | ESCRIBE HOW INJURY OCC | JRRED. | (Enter noture of injury in | Port I or Po | ort II of item 18.) | | | X | |
| MEDICAL | 20c. TIME OF INJ Hour o. | 10 | 20d. I While of wor | Not While | | CE OF INJURY (Home, form ory, street, office bldg., etc.) | | (City or town) | (Co | unty) | (| (Stote) |
| | 21. I certi | fy that (1) (this has | pital) ,atten | ded the deceased fr | om_£ | pr.29,1 | 9_67. | to Apr 29 | , 19 € | 57, th | of (I) (| we) los |
| | sow the d | eceased alive on_ | Apr. 29 | /19_67, on | d tho | t deoth occurred of | 840P | M, from causes | ond on the | he dot | e stoted | obove |
| | 220. SIGNATURE | 10 | 1/ 11/ | / | | ATTENDING | MED. | STAFF OF | | ATE SIGN | ED | |
| | | 171 | Illel | | M.I | D. PHYS. L_I | DIRECTOR | PHYS. | 30 | API | RIL 1 | 967 |
| | OR DUNCTERABLE | | - COLLY | | | 1 224 ADDDECC | | | | | | - |

PHYSICIAN'S NAME (Type)

230.

T.E.KELLY MD 23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City or Town)

1967

Naval Hospital, Bethesda, Md.

(Stote) (County)

BURIAL, CREMATION,
REMOVAL (Specify)
INTELLIFICATION
FUNERAL DIRECTOR
OBJECTION
P Indian Branch Cem. | 250, REC'D BY

FUNERAL HOME DARLINGTON S.C.

REGISTRAR

S.C. DARLINGTON 25b. REGISTRAR'S SIGNATURE
Miles Judge

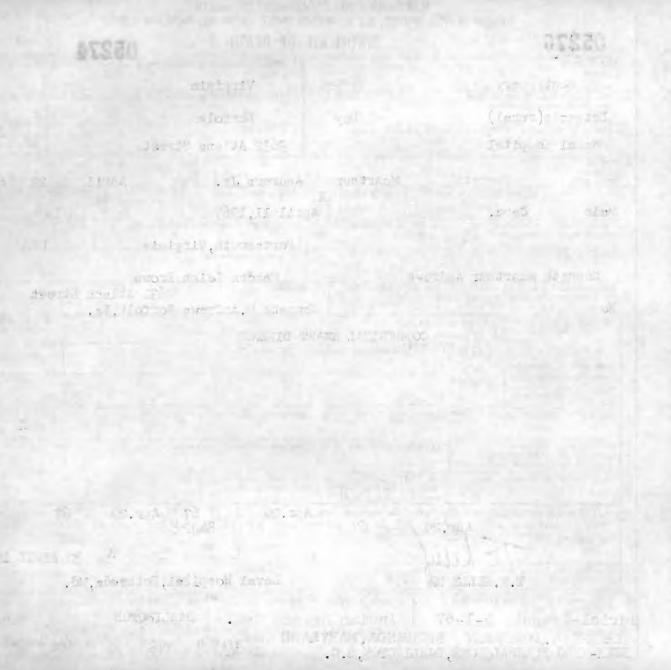
VR A15 (4) 25M 1/67

O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death.

Page 4 may be retained by the hospital or ottending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physicion and completel filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remave carbon papers. Pages 1-and should be filed with the State Dept. of Health prior to buriol, cremation, or removol, and in any event, within 72 hours after Seat

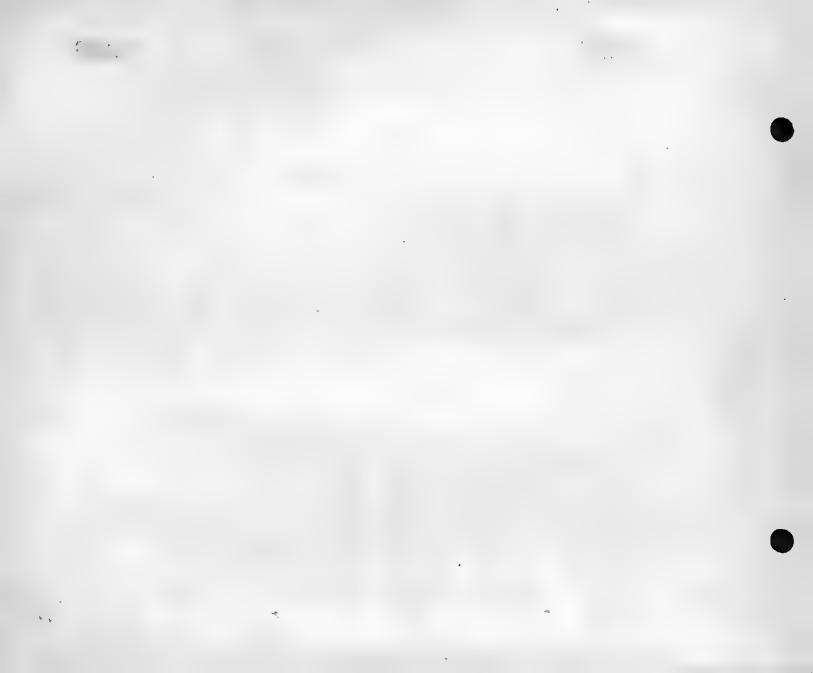
director, page 3 should be detached for use as the burial-transit permit. Then please remaye call should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any eyent,



| × 1 | It | em 18 Film 388 5-8-67 amaryland state department of Health Division of Statistical Research and Records, 301 W. Preston Street, Baltimore, Maryland 21201 |
|--|---------------|--|
| FOR STATE | | 05277 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05275 |
| PM3 delay is PM3 delay is PM3 delay is portment of delay. | 1 | PLACE OF DEATH o. COUNTY b. CITY OR TOWN (if autside corporate limits, write RURAL and give nearest fawn) C. CITY OR TOWN (if autside corporate limits, write RURAL and give nearest fawn) |
| THE BENT | - | d NAME OF HOSPITAL OR NSTITUTION (I FIRST HESPITAL), give street oddress) d. STREET ADDRESS d. STREET ADDRESS on A FARM? FOR CONTROL OF NOTITUTION (I FIRST IN THE PROPERTY OF THE PROPERT |
| after death If a Give Pages 1, along with form with the State De within 72 hours | | DECEASED (Type or print) A DECEMBER OF BIRTH OF DEATH A 1 2 - 96 7 SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED B DATE OF BIRTH 9 AGE (Infraors IFLINDER 1 YEAR FLINDER 24 HRS Min Months Days Hours Min Months Days Hours Min Months Days Hours Min Manner |
| 24 hours in Item 1 r's Office es 1 ond 2 | dur | WIDOWED DIVORCED 1-1-06 BYTS. D. USLAL OCCUPATION (G ve kind of work done ing most of working life, even if retired) STATHER'S NAME WIDOWED DIVORCED 1-1-06 BYTS. 11. BIRTHPLACE (Stoffe or foreign country) LICULATION (G ve kind of work done ing most of working life, even if retired) LICULATION (G ve kind of work done ing most of working life, even if retired) LICULATION (G ve kind of work done ing most of working life, even if retired) LICULATION (G ve kind of work done ing most of working life, even if retired) LICULATION (G ve kind of work done ing most of working life, even if retired) LICULATION (G ve kind of work done ing most of working life, even if retired) LICULATION (G ve kind of work done ing most of working life, even if retired) LICULATION (G ve kind of work done ing most of working life, even if retired) LICULATION (G ve kind of work done ing most of working life, even if retired) LICULATION (G ve kind of work done ing most of working life, even if retired) LICULATION (G ve kind of work done ing most of working life, even if retired) LICULATION (G ve kind of work done ing most of working life, even if retired) LICULATION (G ve kind of work done ing most of working life, even if retired) LICULATION (G ve kind of work done ing most of working life, even if retired) LICULATION (G ve kind of work done ing most of working life, even if retired) LICULATION (G ve kind of work done ing most of working life, even if retired) LICULATION (G ve kind of work done ing most of working life, even if retired) LICULATION (G ve kind of work done ing most of working life, even if retired) LICULATION (G ve kind of work done ing most of working life, even if retired) LICULATION (G ve kind of work done ing most of working life, even if retired) LICULATION (G ve kind of work done ing most of working life, even if retired) LICULATION (G ve kind of work done ing most of working life, even ing most of workin |
| be executed within 24 "pending" in pencil in nief Medical Examiner's onsit permit File pages or removat, and in ony | 15 | HATERY R. HANDREUS. MAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT 200 Kiddress La 11do e 11a |
| shoutd te word the Ch burrol-tra | | IB CAUSE OF DEATH (Enter only one couse per line for (o), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE (AUSE (a) Out TO Conditions, if only which gove rise to immediate couse (o). Stoting the underlying couse (o). (c) Coronary sclerosis, severe S77-C9-547/ Real THAN DEELL'S |
| This certificate cate, writing the forwarded to be used as a large to be used as a large. | CERTIF.CATION | PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDITION GIVEN IN PART I(c) 19 WAS AUTOPSY PERFORMED? YES NO 200 EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of in any in Port Lor |
| INER: ne certifi should files. 3 should | MEDICAL CERTI | PRIMARY Or CONTRIBUTING CAUSE OF DEATH. 20c Time OF INJURY Month, Doy, Year Hour om. p.m. 19 While of work o |
| DEPUTY MEDICAL EXAM ressory, pleose execute the e funeral director. Page 4 may be retained for your FUNERAL DIRECTOR: Page solth or its designated age | | 21. 1 certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from. Natural causes |
| O DEPUTY A necessory, plane funerol of 5 moy be reconsidered to FUNERAL I Health or its | 12. | EXAMINER'S NAME (Type) / 2/8 Samin 22 Rd. Silvey, Md. Address (Street, city, town, or county) ASSISTANT MEDICAL EXAMINER LA DEPUTY MEDICAL EXAMINER LA 4-2-67 Address (Street, city, town, or county) |
| VR AISME (5) | F.7 | BURAL (REMATION, REMOVAL (Specify) 236 DATE THEREOF 237 NAME OF CEMETERY OR (REMATORY 236 LOCATION (City or Town) (County) (Stote) 250 REC'D BY REGISTRAR 250. REGISTRAR S SIGNATURE 250 REC'D BY REGISTRAR 250. REC'D |



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 30] W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE Item #9 Film #G OF DEATH and 2 death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission o. COUNTY b. COUNTY MARYLAND c LENGTH OF STAY IN 16 b (ITY OR TOWN (If autside carparate limits. c CITY OR TOWN (If autside carporate limits, write RURAL and give nearest town) write RURAL and give nearest town Weeks requires that the death certificate be Executed within 24 hours remsing d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) IS RESIDENCE ON A FARM? hensing Ton LIMROLENS NO C NAME OF Middle DATE Year DECEASED 19 67 crson DEATH (Type or print) AGE (In years IF JNDER 24 HRS S SEX 6. COLOR OR RACE NEVER MARRIED Haurs WIDOWED DIVORCED and in any 12 CITIZEN OF WHAT 10a USJA, OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR 11. BIRTHPLACE (County & State or fareign country) COUNTRY? INDUSTRY during most of working life, even if retired) VIRGINIA PATent ATTORNEY 13. FATHER S NAME 14. MOTHER'S MAIDEN NAME W, Anderson 16 SOCIAL SECURITY NO 17 INFORMANT (Yes, no propinown) MANNEVILLE INTERVAL BETWEEN ONSET AND DEATH CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY burial-fransit TERIO- SCLEROT IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate couse (a), DUE TO stating the underlying couse by the haspital ar attending O FUNERAL DIRECTOR: After this certificate has been as the WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) for use of Health NO UCNE 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20a. ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e, PLACE OF INJURY (Home, fgrm, (City ar tawn) (County) (State) 20d. INJURY OCCURRED 20c. TIME OF INJURY Month, Day, Year Hour a.m. factory, street, affice bldg., etc.) Not While ot wark 21. I certify that (I) (this hospital) attended the deceased from 1000 6 Page 4 may be retained 22 1967, and that death occurred at 3 A, M, from causes and on the date stated above. saw the deceased alive on 22o. SIGNATUR 225... DATE/SIGNED ATTENDING M.D. PHYS DIRECTOR PHYS 22d_ADDRESS 22c. PHYSICIAN S NAME (Type) 23d. LOCATION (City or Town) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (County) 23g. BURIAL CREMATION RECD BY REGISTRAR VR A15 (4) 20 M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05273 CERTIFICATE OF DEATH and 2 death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) filled in by the funera papers. Pages I and requires that the death certificate be executed within 24 haurs after de o. COUNTY MARYLAND Montgomeru Montagnery haurs after b CITY OR TOWN (f outside carparate limits, with RURAL and give nearest town) s, CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLENGTH OF STAY IN 16 Silver Spring uears d STREET ADDRESS e. IS RESIDENCE ON A FARM? d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 735 Sligo Avenue Sliao Avenue YES T NO 🗔 NAME OF Middle Lost 4 DATE Month Year Doy DECEASED signed by the attending physician and campletel burial-transit permit. Then please remave sarbs Klein Josephine event, (Type or print) DEATH 1967 IF UNDER 1 YEAR IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE 7. MARRIED DATE OF BIRTH AGE (In years NEVER MARRIED Mar 2. 1893 last birthdoy) Months Hours ony WIDOWED DIVORCED Female (aucasion 10o USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11 BIRTHPLACE (County & State, or foreign country) COUNTRY during most of working life, even if retired) INDUSTRY ondi New Jersey
14. MOTHER'S MAIDEN NAME wn home 13. FATHER'S NAME crematian, ar remaval, Michael Klein Caroline Dietien IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Stago Avenue (Yes, no, or unknown) (If yes give wor or dotes of service) Grover E. Sprina. 18. CAUSE OF DEATH (Enter only one couse per line for (a) (b), and (c).) INTERVAL BETWEEN PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (6) DUE TO burial, Conditions, if ony, which gove (b) rise to immediate couse (a), DUE TO stoting the underlying couse IN FUMIRAL DIRECTOR: After this certificate has been PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) WAS AUTOPS)
PERFORMED? NO K 200 ACCIDENT WAS UNDERLYING 205, DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18) OR CONTRIBUTING CAUSE OF DEATH be detached State D≡pt. af (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20s. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour o.m. factory, street, office bldg., etc.) Not While of work at work 21. I certify that (1) (this-hospital) attended the deceased fram_ . 19 64. ta (1) (we) last LAn. ro Hospital or Attent saw the deceased alive an Man. 31 1967, and that death accurred at 5 P M, fram causes and an the date stated above. 220. SIGNATURE 22b. DATE SIGNED MED. DIRECTOR STAFF PHYS. Aleman UL **ATTENDING** 4/10/67 director, page should be filed 22d. ADDRESS 22c. PHYSICIAN'S Coleman, M.D. James R. NAME (Type) 9241 Columbia Blud. Silver Spring Md 230. 8URIAC CREMATION, 23b DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) REMOVAL (Specify) North Bergen, New Jersey Flower Hill Cemetery FUNERAL DIRECTOR VR A15 (4) 20 M 1/66



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shauld be detached far use as the burial-transit permit. Then please remove carban papers. Pages 1 and shauld be filed with the State Dept. of Health prior to burial, crematian, or remaval, and in any exemt, within 72 hours after death.

35280

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

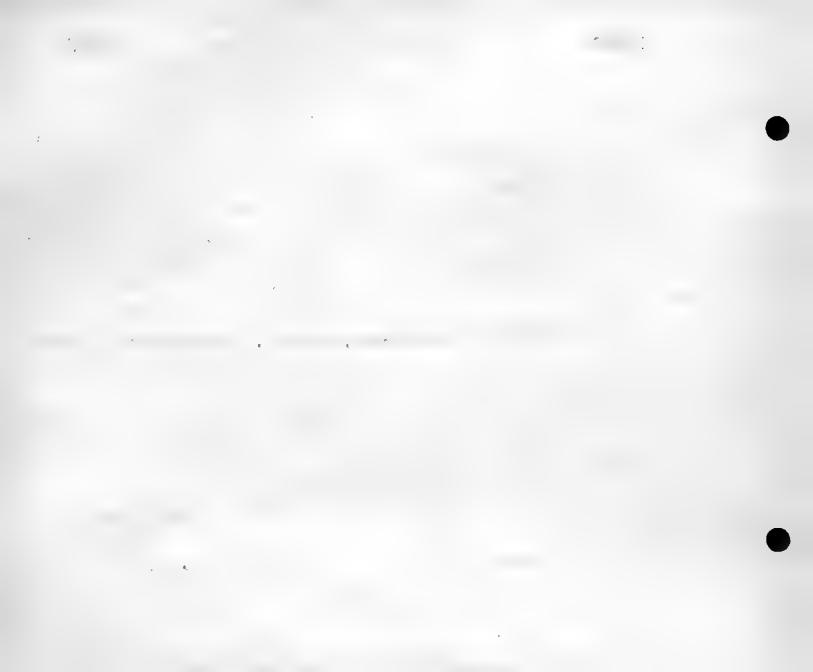
| U528 | J | | CERTIF | ICATE | OF DEATH | | 15270 | |
|------------------------------------|---|-------------------|----------------------------|--------------|---|---|--|-----------------------------------|
| 7. PLACE OF DEATH | 1 | | | | | Where deceased lived, if institu | | ne ogu ssiou) |
| d. COMIT | MONTGOMERY | | MAR' | YLAND | DIS DIS | TRICT OF COLU | MBIA / | V |
| | (If outside corparate limit and give nearest tawn) | \$, | C LENGTH OF STAY | IN 1b | c CITY OR TOWN (If ou | itside corporate lim'ts, write RU | JRAL and give neare | ist tawn) |
| BETH | ESDA (RURAL) | | 3 HRS 16 | MIN | | ngton- | | * |
| d NAME OF HOSE | PITAL OR INSTITUTION (If n | at in haspital, g | give street address) | | d SEPTADDRESSO | l. | I | B IS RESIDENCE ON A FARM? |
| NAVA | L HOSPITAL | | | | 5038 LIVII | NGSTON_TERRACE | S.E. | YES NO K |
| NAME OF DECEASED | F | rst | Middle | | Last | 4. DATE Mor | nth Do | у Үеат |
| (Type or print) | ELEAN | IA. | | | BANDONG | DEATH APRIL | | |
| SEX | 6. COLOR OR RACE | 7 MARRIED | NEVER MARRIE | · 👪 | DATE OF BIRTH | 9 AGE (In years last birthday) | Months Doys | |
| FEMALE | MALAYSIAN | WIDOWED | DIVORCE | | APRIL 14, 1 | 1967 yrs | | 24 |
| | ON (Give kind of work done ng life, even if retired) | | IND OF BUSINESS OR IDUSTRY | | 11. BIRTHPLACE (County | & State, or foreign country) | 12. CITIZEN C COUNTRY |)F WHAT |
| | NA | | NA | | | MONTGOMERY, 1 | (D) | USA |
| 3. FATHER'S NAME | | | | | 14 MOTHER'S MAIDEN I | | | |
| | Q. BANDONG | | | | MARIA SAI | | | |
| | VER IN U.S. ARMED FORCES? (If yes give wor or dates) | | SOCIAL SECURITY NO | | - 4 | 301 WASHINGTON | | |
| NA | DEATH (Enter anly one car | | NA | RU | DOLFO Q. BAI | NDONG, 5038 L | | TERR.S.E |
| | ny, which gave attention of the course (o), derlying cause | (b) | | | | | | |
| PART II OTHER | SIGNIFICANT CONDITIONS | ONTRIBUTING 1 | TO DEATH BUT NOT RE | LATED TO 1 | HE TERMINAL DISEASE CON | NDITION GIVEN IN PART 1(a) | 19 | WAS AUTOPSY PERFORMED? YES NO |
| OR CONTRIBUTION | VAS UNDERLYING □ NG □ CAUSE OF DEATH FY MEDICAL EXAM.NER) | 20b DF | SCRIBE HOW INJURY O | CCURRED | Enter nature of injury in | Part I ar Port II af item 18) | | |
| E Hour | p m. 19 | While at war | k 🔲 at wark 🔲 | fact | E OF INJURY (Home, farm ary, street, office bldg., etc.) | | (County) | (State) |
| 21. I cer saw the | tify that (I) (this has deceased alive on_d | pital) attend | ded the deceased | framand that | APRIL 14 , 1 death occurred at | 967 , to APRIL . 0420AM, fram causes | 14 , 19 <mark>57</mark> , t ond an the da | hat 🐴 (we) las te stated above |
| 22a. SIGNATUR | Jenn Jenn | 1.400 | nasou | -< MI | 11111 | MED. STAFF DIRECTOR PHYS | 22b. DAVE SIG 14 Apr | . 1967 |
| 22c. PHYSICIAI NAME (Ty | | roasmbT | vic, MD | | Naval Ho | spital, Bethe | sda, Md. | |
| 230 BURIAL, CREMA REMOVAL (Spec | TION, 23b DATE TH | ERLOF 167 | 23¢ NAME OF CEM | | | 23d LOCATION (City or To | | (Store) |
| 24 FUNERAL DIREC | | HAMPERS | co.//222 | | | BY REGISTRAR 250 8 | ECASTRAR S SIRNATI | Rudala |
| 1400 CHA | PIN STREET. | N.W. | WASHINGTO | N. D. | C. DATEAP | R 1 8 1967 / | Charles | 10 |

Page 4 may be retained by the haspital or attending physician. VR A15 (4) 25M 1/67

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death.

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MARYLAND STATE DEPARTMENT OF HEALTH Item #0 infor. taken from birth cort. 05279 PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) ny delay .s 2, and 3 to PM3 Page 5 MARYLAND JOWN (If outside corporate limits. b CITY OR CLENGTH OF STAY IN 16 c CITY OR JOWN (If outside corporate lymits, write RURAL and give nearest town) e. IS RESIDENCE d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, should be forwarded to the Chief Med cal Examiner's Office along with form This certificate should be executed within 24 hours after death. If NAME OF Middle DECEASED Type or print) DEATH 7. MARRIED NEVER MARRIED Months Days ony event within 72 hours ofter deoth. WIDOWED DIVORCED 12 CITIZEN OF WHAT 100 USUAL OCCUPATION (Give kind of work done 10b K ND OF BUSINESS OR during most of working life, even if refired) INDUSTRY 13. FATHER'S NAME 14 MOTHER S MAID! 17 INFORMAN 16 SOCIAL SECURITY NO (Yes no, or unknown) ((If yes give wor or dates of service 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) buriol-transit ONSET AND DEATH PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Brenchepheumenia, bilateral, interstitial type heurs DUE TO Conditions, if any, which gave (b) rise to immediate cause (a), DUE TO stating the underlying couse 3 should be used removal PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDITION GIVEN IN PART 1(6) CERTIFICATION YES 🔼 NO 200 EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port II of item 1B.) PRIMARY Or CONTRIBUTING CAUSE OF DEATH. MEDICAL 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form (City or town) (State) 20c. T.ME OF INJURY Month, Doy, Year foctory, street, office bldg., etc.) ot work 21. I certify that I took charge of the remains described above, held an Autopsy Inspection 💢 Inquiry XI. and in my opinion 5 may be retained for 0 FUNERAL DIRECTOR: Natural causes X. Accident . Suicide . Undetermined monner deoth resulted from: Hamicide the funeral director CHIEF MEDICAL EXAMINER ACTUAL ASSISTANT MEDICAL EXAMINER Heo th prior SIGNATURE DEPUTY MEDICAL EXAMINER **EXAMINER'S** Address (Street, city, town, or county) NAME (Type) 230 BLR AL CREMATION 23c NAME OF CEMETERY OR CREMATORY 23d LOCAT ON (Cay or Town) (State) REMOVAL (Specify) Gartner 24. FUNERAL DIRECTOR Ernes ADDRESS VR A15ME (5)1 } Gaithersburg. Md 6M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05282 CERTIFICATE OF DEATH **ATTENDING PHYSICIAN:** The low requires that the death certificate be executed within 24 hours after death 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) 1. PLACE OF DEATH o. COUNTY o. STATE **b** COUNTY MARYLAND b CITY OR TOWN (If ourside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 outside corporate limits, write RURAL and give neagest town) e carbon papers. Page Sockulle d STREET ADDRESS e. IS RESIDENCE ON A FARM? d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) filled YES NO X 3 NAME OF First Middle Lost DATE completely nove carbon DECEASED ALENCE DEATH (Type or print) IF UNDER YEAR 8. DATE OF BIRTH AGE (In years IF UNDER 24 HRS. S. SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED 7 st birthdoy) Months Doys Hours D VORCED WIDOWED or remayol, and in ony 12. CITIZEN OF WHAT 10b. KIND OF BUSINESS OR 11. BIRTHPLACE./County & State, or foreign country) 10o USUAL OCCUPATION (Give kind of work done physician a COUNTRY? during most of working life, even if retired) INDUSTRY w.C.D. Cival Engineer 14 MOTHER'S MAIDEN NAME 13. FATHER'S NAME IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT (Yes, no. as yoknown) (If yes give wor or dates of service) 173-20-3101 outh A. Bordsley e rbove ife buriol, cremation, INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c),) ONSET AND DEATH burial-transit PART 1. DEATH WAS CAUSED BY: spontaneous Intracerebral Hemorrhage, right IMMEDIATE CAUSE (o) signed by 3311 DUE TO 2 days Rupture right middle eerebral artery Conditions, if any, which gove " (b) rise to immediate couse (a), DUE TO stoting the underlying couse O FUNERAL DIRECTOR: After this certificate has been the Health prior to Advanced cerebral arterioselerosis vears for use as PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) WAS AUTOPSY PERFORMED? CATION Hypertensive Heart Disease YES A NO hospitol or 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of Item 18.) 20 o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) State Dept. 20d. INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Day, Year factory, street, office bldg., etc.) Hour o.m. Not While While 19 at work of work 19 60 C) to CP 21. I certify that (I) (this haspital) attended the deceased fram. retoined director, page 3 should should be filed with the 19 C 7, and that death accorded at 12 12 M, from causes and an the date stated above. saw the deceased alive and 22b. DATE SIGNED 220. SIGNATURE ATTENDING PHYS DIRECTOR . M.D. 22d. ADDRESS Paronaton Drive Bowditch Hunter, Rockvi NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) 23o. BURIAL, CREMATION, 23b. DATE THEREOF Bur-Ir not Tolla Cometary Rolla. Miscouri 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE ADDRESS 24. FUNERAL DIRECTOR Villanes VR A15 (4) 'ome13 1 Nock. Pike heeler funeral DATAPR 2 20 M 1/66

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05283 CERTIFICATE OF DEATH PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death by the funeral Pages 1 and quo PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) Montgomery o. STATE b. COUNTY Maryland Montgomery MARYLAND b CITY OR TOWN (If autside carparate limits, c LENGTH OF STAY IN 16 c CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) write RURAL and give negrest town? Bethesda Bethesda 9 days d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e IS RESIDENCE ON A FARM? The Clinical Center, Bethesda, Maryland 5528 Johnson Avenue YES NO TO NAME OF 4. DATE Last Month Day Year DECEASED OF DEATH Morris Karlynn April (Type or print) Barrett 19 67 S. SEX 6. COLOR OR RACE DATE OF BIRTH AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 7 MARRIED **NEVER MARRIED** the attending physician and campait between last birthday) White Malle WIDOWED DIVORCED 18 August 1900 10a USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired)
Physician INDUSTRY COUNTRY? Medicine Kentucky USA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME J. Morris Barrett Thomasann Payne 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT The Medical Recorddress (Yes, ng, ar unknown) (If yes give war ar dates of service) & II The Clinical Center, Bethesda, Maryland Yes 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). INTERVAL BETWEEN ONSET AND DEATH signed by the burial-transit p PART I, DEATH WAS CAUSED BY Bronchogenic Carcinoma IMMEDIATE CAUSE (o) months DUF TO Conditions, if ony, which gave rise to immediate cause (o). DUE TO stoting the underlying couse TO FUNERAL DIRECTOR: After this certificate has been for use as the PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? CERTIFICATION YES KI NO F 20a ACCIDENT WAS UNDERLYING [20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) O HOSPITAL OR ATTENDING PHYSICIAN Page 4 may be retained by the haspital OR CONTRIBUTING CAUSE OF DEATH should be detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Hame, form, (City or town) (County) (State) Nat While Haur a.m. factory, street, affice bldg., etc.) 21. I certify that (1) (this haspital) attended the deceased fram 28 March 1967, to 6 April __, 1967, that (1) (we) last 1967, and that death accurred at 6:25 M. fram causes and on the date stated above. saw the deceased glive an 6 April 22a. SIGNATURE 22b. DATE SIGNED **ATTENDING** STAFF PHYS. 7 April 1967 M.D. DIRECTOR 22d. ADDRESSThe Clinical Center, National 22c, PHYSICIANS NAME (Type) Martin H. Cohen. M.D. Institutes of Health, Bethesda, Md directar, should be 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION 23b DATE THEREOF (Caunty) (State) REMOVAL (Specify) UITLAND REMATEC 250. RECD BY REGISTRAR DATE PR 1 2 19 24 FUNERAL DIRECTOR REGISTRAR'S SIGNATURE VR A15 (4) S ASHINGTON, DC.



| , 1 | te | ms 18&21 Film 390 6-22MARYLAND STATE DEPA | |
|--|---------------|---|--|
| FOR STATE | | 05907 | CERTIFICATE OF DEATH 05282 |
| HEALTH DIPT. | 1 | PLACE OF DEATH O. COUNTY MARYLAND MARYLAND | 2 USUAL RESIDENCE (Where deceosed lived, if institution Residence before admission) b. COUNTY b. COUNTY C CITY OR TOWN (F outside carporate limits, write RURAL and give nearest town) |
| thin 24 hours after death. If Cary delay not, In Item 18 Give Pages 1, 2, and 3 miner's Office along with form. PM3. Pages I ond 2 with the State Department ours after death. | | 6 CITY OR TOWN (If outside corporate lim is, write RURAL and give neares own) | ADELPHI |
| es 1, 2, form Form February | | d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | d STREET ADDRESS 1818 METZ EROTT B IS RESIDENCE ON A FARM YES NO X |
| I within 24 hours after death in pencl in Item 18 Give Page Examiner's Office olong with File pages I ond 2 with the Store I hours after death | L | NAME OF DECEASED (Type or print) LORRAINE GARNES | THE BARRY DEATH APRIL 24 1967 |
| hours after 18 GO Office olon Iond 2 with | | FEMALE WHITE WIDOWED DIVORCED | 8 DATE OF BIRTH 7-1-23 9 AGE (In years as outlineday) 4 Structure of the property of the prope |
| 24 hours in Item I sr's Office les I ond 2 after deat | dur | I USLA. OCCUPATION (Give kind of work done ing most of working life, even if retired) FATHERS NAME | 11 BIRTHPLACE (State or foreign country) 12. CIT ZEN OF WHAT COUNTRY? AMER. |
| d within in pencil Examine File pag | 10. | HARTWELL SMITH | MARY INFORMANT Address |
| nit n 7 | (Ÿe | as an ar unknown) (If was give war or dates of service) | LAINE BARRY, AS ABOVE (DTR.) |
| should be e te word "pen to the Chief A bur ol-tronsit | | | Fatty metamorphosis ONSET AND DEATH |
| s certificate should be exect e, writing the word "pending forwarded to the Chief Med used as a bur al-transit per loval, and in any event within | | Canditians, if any, which gave rise to immediate cause (a), stating the underlying couse | |
| This certificate cate, writing the be forwarded it be used as a removal, and in | NO | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO | PERFORMED? |
| FR: This certificate, ould be foes. should be unit or remon, or remon, | CERTIFICATION | PRIMARY □ or CONTRIBUTING □ | (Enter nature of injury in Part or Part II of term 18.) |
| 로 의 속 표 뜻 일 | MEDICAL CI | Haur a.m. While Mat While For | ACE OF NJURY (Hame form, 20f (City or tawn) (Caunty) (State) tary, street, affice bldg., etc.) |
| AL EXA EXA EXECUTE Page for you OR: Pagi | | 21. I certify that I taak charge of the remains described above he death resulted from: Natural causes X, Acquent Suice | eld an Autapsy Inspection X, Inquiry and in my apiniar |
| MEDICAL EXAMINATION Please execute the director. Page 4 sherined for your fill DIRECTOR: Page 3: To buriol, crematic | | ACTUAL SIGNATURE Delicer A las | CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER 23. DATE SIGNED |
| rry, Probe per | | EXAMINER'S NAME (Type) BELDEN R KEAR A | 1. D. Middess Kined, Phys town to county) 4/24/1967 |
| TO DEPU necessal the funds 5 may 1 TO FUNE | | | n Cemetery Prince Georges County, M |
| VR A15ME (5) - 6M 1/67 | 24 | 2901 14th St. N.W. Washington, | .C. 250 RECD BY REGISTRAR 250 POLEAR S GNATULE |

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TO FUNERAL DIRECTOR: After this certificate has been signed by the ottending physician ord-completely filled in by the uneral director, page 3 should be detached for use as the burial-transit permit. Then please cemave carbon papers. Pages conditionally should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. OR ATTENDING PHYSICIAN: The law requires that the death certificate be sxecuted within 24 hours after. **TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires tha Poge 4 may be retained by the hospital or ottending physicion.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

| 0528 | 5 | | CERTIFICA | TE (| OF DEATH | | | 05 | 283 | 3 | j |
|--|---|----------------------------|--------------------------------|---------|--|------------------|----------------------------------|------------------------|----------------|----------------------|-------------------|
| 1. PLACE OF DEATH o. COUNTY Montgor | nery | | MARYLAND | | USUAL RESIDENCE () O. STATE Virginia | | ceosed lived, if instit b. CO | ution: Resider UNTY | ce before | odmission | 1 |
| b. CITY OR TOWN | (If outside corporate limit and give nearest town) | ts, | c. LENGTH OF STAY IN 1b | - | CITY OR TOWN (If ou | | porote limits, write R | URAL ond giv | e neorest | town) | |
| Bethes | | | 37 Mins | | McLean | | | | | | |
| d NAME OF HOSP | ITAL OR INSTITUTION (If n | ot in hospitol, g | ive street oddress) | | i. STREET ADDRESS | | | | e. | ON A FAI | ENCE RM2 |
| Naval H | lospital | | | | 1244 Tita | ania | Lane | | Y | ES 🔲 I | |
| 3. NAME OF DECEASED | F | irst | EMiddle | | Last | 4 DAT | - | nth | Doy | Year | 1 |
| (Type or print) | Henry |] | Leidinheimer | | Beardsley | DEA | | ril | 8 | | 67 |
| 5 SEX | 6. COLOR OR RACE | 7. MARRIED | X NEVER MARRIED | 8. | DATE OF BIRTH | | 9. AGE (In years lost birthdoy) | Months 1 | 1 YEAR Doys | IF UNDER Hours | 24 HRS |
| Male_ | Cauc | WIDOWED | DIVORCED _ | | July 191 | | 52 YIS | | | | |
| 100 USUAL OCCUPATIO during most of workin | IN (Give kind of work done a life, even if retired) | | ND OF BUSINESS OR DUSTRY | | 11. BIRTHPLACE (County | & Stote, o | r foreign country) | | TIZEN OF | WHAT | |
| USNavy | g, 0.00 II (0.1100) | ALT | 1VE D074 | | Lousiana | | | US | | | |
| 13 FATHER S NAME | | | / | 1 | 4. MOTHER'S MAIDEN I | NAME | | | | | |
| | Harold Bea | ardsley | | | Helen G | antt | | | | | |
| (Yes, no or unknown) | /ER IN U.S. ARMED FORCES?)](If yes give wor or dotes | of service) | OCIAL SECURITY NO. 1 | 17. INF | DRMANT | | Ado | McLear | ,Va. | | |
| Yes | | | 3 26 0576 | Mrs | . Virgini | a M. | | y 124 | 4 Ti | tani | a_La |
| Conditions, if on rise to Immedia stoting the und lost. | y, which gove) ote couse (o), | TO | ardial infar | | | se | | | | | |
| PART IL OTHER : | SIGNIFICANT CONDITIONS (| CONTRIBUTING TO | O DEATH BUT NOT RELATED | TO THE | TERMINAL DISEASE CON | NDITION C | GIVEN IN PART 1(0) | | | WAS AUTO PERFORME | PSY D? 10 🔲 |
| OR CONTRIBUTIN | AS UNDERLYING G CAUSE OF DEATH Y MEDICAL EXAMINER) | 20b DES | CRIBE HOW INJURY OCCURR | ED. (En | ter noture of injury in | Part 1 or | Port II of item 18) | | | | |
| 물 Hour o | JURY Month, Doy, Year i.m. 19 | 20d IN While of work | Mot While | | OF INJURY (Home, form, street, office bldg , etc.) | | f (City or town) | (Co | unty) | 2) | tote) |
| | | | ed the deceased from | 1 | , 1 | | , to | , 19_ | , the | it (I) (w | ve) las |
| | deceased alive an 🕹 | 3 April | 19 <u>67</u> , and 1 | that d | eath accurred at | 0637 | _M, tram cause: | | | | abave |
| 22o S GNATURI | Jack Co | Zin | memen | M.D | | MED. DIRECTOR | STAFF PHYS. | × 120 0 | ATE SIGNE | 67 | |
| 22c. PHY SICIAN NAME (Typ | Jack E. Z | immerma | n | | USNH, Be | thes | da, Md. 2 | 20014 | , | | |
| 230 BURIAL CREMAT | | // | 23c NAME OF CEMETERY Arlington | | ional | 1 | LOCATION (City or Arlington | , | (County) | ٧٤ | ote) B.• |
| 24 FUNERAL DIRECT | OR | | ADDRESS | | 25 percu | BY REG | ISTRAR 25b | REGISTRAR'S | GNATUR | | |
| W. W. | Chambers | 1400 C | hapin St. NW | , W. | DC DATE TO | TI | 1901 | horle | Jus | 72 | |

VR A15 (4) 25M 1/67

| | MARYLAND STATE DEPARTMENT OF HEALTH |
|---|--|
| | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 |
| FOR STATE | 5286 Them #3 FilmMedical Examiner's CERTIFICATE OF DEATH 05287 |
| HEALTH DEPT. | 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admissing) |
| 7 5 9/30 75 | maryland have york Westchester |
| 3/3 PA / 15 | b. CITY OR TOWN Of outside connecte limits. c. LENGTH OF STAY IN 1b c. CITY OR TOWN of outside connecte limits, write RURAL and give necrest town.) |
| 4 9 5 4 | Refinesation of the RURAL and give nearest toyon D.O.A. Thomas and The Sales |
| an an a | d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS e. IS RESIDENCE ON A FARM? |
| ath. If any delay ages 1, 2, order the farm PM3 To State Department | Juburban Hospital- 128 Kingo Chara- VIS NOD |
| offer death. 8. Give Pages adong with far With the State | 3 NAME OF DECEASED Fire Middle Matthew Last 4 DATE Month Doy Year |
| em 18. Give P ffce dong wi and with the | (Type or print) Alever 1 Market kild () Christical DEATH 7 196/ |
| offer 8. Give offer of one of | S SEX 6 COLOR N KACE 7 MARRIED NEVER MARRIED X 8 DATE OF BIRTH 9 AGE (In years IF JNDER I YEAR IF UNDER 24 HR |
| | MIDOWED DIVORCED JULY 20 1739 27 YIS |
| | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR II. BIRTHPLACE (State or foreign country) 11c. BIRTHPLACE (State or foreign country) |
| | |
| within pencil xaminei ile poge haurs o | 13. FATHER'S NAME |
| with per Exam File 1 | Steven Benkovich Anna Straub |
| ol Ey | 15. WAS DECEASED EVER IN J. S. ARMED FORCES? (Yes, no. or unknown) (If yes give word dates of service) 16. SOCIAL SECURITY NO 17. INFORMANT Brother Address Same as Item 2. |
| executed anding" in Medical E t permit. I | Tebdriftes #27-30-3350; Int 6 Bellikovich |
| s certificate should be executed within 24 h, writing the word "pending" in pencil in the forwarded to the Chief Medical Examiner's Cused as a buriol-transit permit. File pages 1 hoval, and in any event within 72 haurs after | 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY- IMMEDIATE (ALISE (a) SONSEL AND DEATH SOURCE OF DEATH (Enter only one couse per line for (a), (b), and (c).) |
| should be en word "per a the Chief, buriol-transit | Think the state of |
| ould word he (| Conditions, if ony, which gove) DUE TO AUTOMORILA ACCEPENT |
| e shoulthe wo | nse ta immediate cause (a). |
| fitate ing th rded as a ond i | last. (c) |
| certificate should writing the word rwarded to the Classed as a buriol-truval, and in ony ev | PART II OTHER S CHIEICANT CONDITIONS CONTRIBUTING TO DEATH RET NOT RELATED TO THE TERMINA DISEASE CONDITION GIVEN IN PART I(a) |
| this certificate, writtee forwar | PERFORMED? YES NO [200. EXTERNAL CAJSE WAS 200. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II of item 18.) |
| e e e e | 20a. EXTERNAL CAJSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.) PR MAR (**Por CONTRIBUTING |
| | PRIMARY DO CONTRIBUTING Driving Sert Crashed into Auto Cressing highway at interse |
| EXAMINER: ute the certif age 4 should your files. Page 3 shoulc | 20c TIME OF INJURY Manth, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, farm 20f. (City or town) (County) (State) |
| ₹ 1 4 7 9 5 ' · | 4 four 4/8 1967 While Not While of foctory, street office bldg. etc.) Chevy Chase Montgoneig M |
| MEDICAL EXA please execute director. Page estained for you DIRECTOR: Pag | 21. I certify that I taak charge of the remains described above, held an Autapsy X, Inspection X, Inquiry X, and in my apini |
| rical te exector. Prod fo buriol, | death resulted fram: Natural causes , Accident , Suicide , Hamicide , Jndetermined manner |
| MEDICA lease endurector durector estained DIRECT to burit | CHIEF MEDICAL EXAMINER |
| Mea pleas dure dure DIR rr to | ACTUAL SIGNATURE ASSISTANT MEDICAL EXAMINER (22. DATE SIGNE |
| JTY N rry, ple eral d be ret be ret prior i | EXAMINER'S DEPUTY MEDICAL EXAMINER X |
| TO DEPUTY MEDICAL E necessory, please exect the funeral director. Po 5 may be retained for TO FUNERAL DIRECTOR: Health prior to buriol, | NAME (Type) JOHN G. BALL Address (Street, city, town, or county) Bethesda, Md. |
| O D D D D D D D D D D D D D D D D D D D | 230 BURIAL (REMATION, 23b DATE THEREOF 28 NAME OF CEMPTER OF TREMATORY 23d. LOCAHON (City of Date Thereof) (Stote) |
| F F | Buryal 4-11-6/ Zala of Heaven term. Paralla, 11-7 |
| VR A15ME (5) | 250. REC'D BY REGISTRAR 250 REG STRAR S SIGNATURE ROLLING LANGE STRAR S SIGNATURE ROLLING LINES LINES |
| 6M 1/67 | Themera mod MEN 1 & SOI / |

de. Y

| | Items 18-21 F | 'ilm 388 5−1-M | ARYLAND STATE DEP | ARTMENT OF HEAL | TH | |
|--|--|----------------------------------|-----------------------------|---|--|---|
| 1 , 1 | | DIVISION OF VITAL F | RECORDS, 301 W. PRESTO | ON STREET, BALTIMOR | E, MARYLAND 21201 | • |
| FOR STATE | 05287 | MED | ICAL EXAMINER'S | CERTIFICATE OF | DEATH | 05288 |
| HEALTH DEPT. | 1 PLACE OF DEATH | | | il critt | ere deceosed lived, if Institution | Residence before admission) |
| Od is | o. COUNTY - AA o | ntgomery | MARYLAND | | tand- | Montgomery. |
| (I) | b CIY OR TOWN (If outs | ride corporate Lmits | C LENGTH OF STAY IN 16 | | de corporote limits, write RLRAL i | and give nearest town) |
| d d d d | write RURAL and give | Chase- | | | 4 Chose- | 131 |
| De la la | | NSTITUTION (If not in hospitol, | | d STREET ADDRESS | onnecticuts | 8 IS RES DENCE ON A FARM? |
| are date | /_/ | Connecticul | | 11 | | 1 10 10 10 |
| fer death 1 Give Pages ong with far the state | 3 NAME OF DECEASED (Type or print) | Pauline | Middle N • | Benton | 4 DATE Month OF DEATH APRIL | Doy Year 16 19 6 7 |
| ong of the | | OLOR OR RACE 7. MARRIED | NEVER MARRIED | B. DATE OF BIRTH | | UNDER YEAR IF UNDER 24 HRS |
| Is of the contract of the cont | 7e. | W . WIDOWED | D VOR CED | 3/23/3 | 1 36 yrs | |
| hau tem Offic and | 10o. JSUAL OCCUPATION (G ve during most of working life, ev | | IND OF BUSINESS OR IDUSTRY | 1." BIRTHPLACE (State or | " | 12 CTIZEN OF WHAT COUNTRY? |
| 24 in l ir's (es l aftel | Bioche | mist | | | 1:50ta- | U.S.A |
| hin ncil nine pag | 13 FATHER'S NAME | m.00 | | 14 MOTHER'S MAIDEN NA | 1 | |
| will per Exar | 15. WAS DECEASED EVER IN U | C ADMED CODYECT | SOCIAL SECURITY NO. 17. | INFORMANT IT | nd Perk | ins |
| Jing Coll and Mit. | (Yes, no, or unknown) (If yes | give wor or dotes of service) | - IT | ane A. Bent | | s Item 2. |
| e shauld be executed within 24 haurs a the word "pending" in pencil in Item 18 ta the Chief Medical Examiner's Office a bunal-transit permit. File pages Land 2 w in any event within 72 haurs after death. | NO | Enter only one couse per line fo | 14448141111 | ane A. Dem | COIL | NTERVAL BETWEEN |
| pe e 'per / jef / ief / int / int / | PART I. DEATH WA | C CALICED BY. | 50/14 - Barbiti | rate noison | ine | ONSET AND DEATH |
| eve eve | 97/7 | DUE TO | 11/11/11 | <u> </u> | | |
| shau the urial | Conditions, if ony, which | h gove) (b) OT | erdose of Tui | nal and alc | ohol | |
| the the date of th | rise to immediate cou stating the underlying | | | | | |
| ificate ting ting ting tinded inded as a | lost. |) (c) | | | | |
| EXAMINER: This certificate should be executed within 24 hours after death. If a cut the certificate, writing the word "pending" in penal in Item 18 Give Pages 1, age 4 should be farwarded to the Chief Medical Examiner's Office along with farm your fles. Page 3 should be used as a burial-transit permit. File pages Land 2 with the Mate Decremation, or remayal, and in any event within 72 hours after death. | PART OTHER SIGN.FIC 200 EXTERNA. CAUSE W PRIMARY 10 or CONTRIBU | ANT CONDITIONS CONTR.BLTING | TO DEATH BUT NOT RELATED TO | THE TERMINAL DISEASE CONDI | IT.ON GIVEN IN PART 1(0) | 19. WAS AUTOPSY PERFORMED? YES NO |
| The Table I a be | 200 EXTERNAL CAUSE W PRIMARY Or CONTRIBU | HTING - | ESCRIBE HOW INJURY OCCURRED | | | |
| certicerticerticerticerticerticerticerti | CAUSE OF DEATH | To | ok overdose o | | | |
| | 20c TIME OF NIJRY N | | NJURY OCCURRED 20e PLA | CE OF INJURY (Home, form, topy, street, office bldg., etc.) | , , | |
| XAM ute th ge 4 yaur Yage rrema | A DE | | K - DI WOIK - | | | |
| of, DR. P. P. C. | | - | | | | X, and in my apinion |
| se exector Production for the formal | death resulted to | ram. Natural causes L | , Accident [| ide 🔼, Homicide [Chief Medical Ex | , Undetermined mont | ier |
| MEDI please direct direct retaine DIREC | ACTUAL | John S. B. | el. | M.D. ASSISTANT MEDICA | | 22. DATE SIGNED |
| JTY MEDIC ry, please e erol director be retained RAL DIRECT prior to bur | SIGNATURE | | | DEPUTY MEDICA. | | 157 |
| necessary, please execute the funeral director Page 4 5 may be retained far yaur 10 FUNERAL DIRECTOR: Page Health prior to burial, crema | NAME (Type) | JOHN G. BAT | | | city, town or county) Reth | esda_Md |
| o D D D D D D D D D D D D D D D D D D D | 230. BURIAL, CREMATION, | 23b DATE THEREOF | 23c NAME OF CEMETERY OR | | 23d LOCATION (City or Town) | (County) (State) |
| 1 2 2 | Buffia (pealy) | 4-19-67 | RockGreek | Cemetery | Washington | and Do - Cand |
| VR A15ME (5) 6M 1/67 | ROBERT A. | PUMPHREY, B | ethesda, Mar | yland APR 2 | 2 4 1967 golis | rars, gnature |
| | | | | | The second secon | . z z/z = ±/= ============================= |



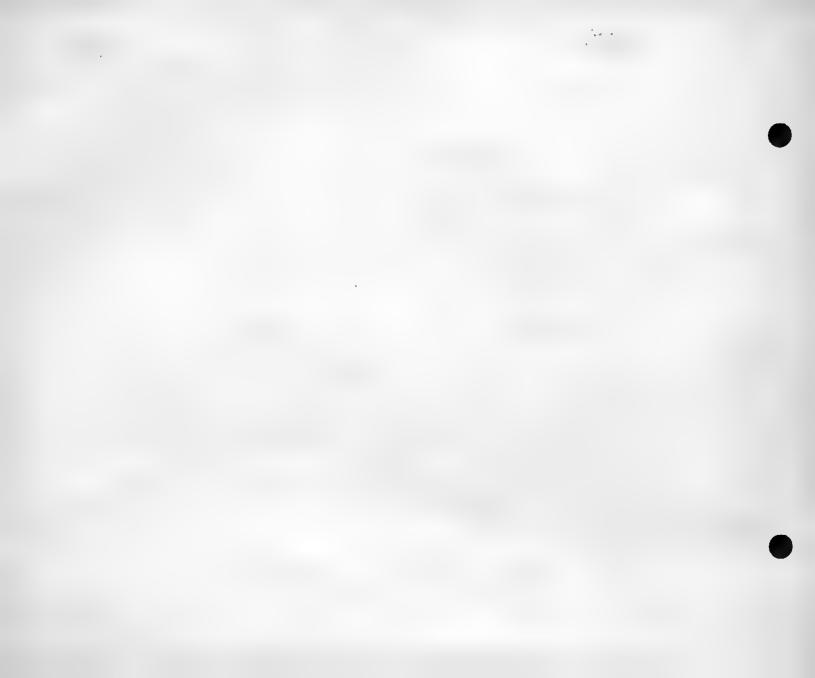
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH The low requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission and ours after dea a. COUNTY a. STATE b. COUNTY MARYLAND CITY OR TOWN (If outside corporate limits c LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) filled in e IS RESIDENCE NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS ON A FARM Middle DATE Year remove corbon and completely DECEASED 19 DEATH AGE (In years NEVER MARRIED last birthday) Months Days in any WIDOWED DIVORCED 10b KIND OF BUSINESS OR 12 CITIZEN OF WHAT physician o during most of working life, even if retired INDUSTRY and 0050 411 PATHER'S NAME 14. MOTHER'S MAIDEN NAME has been signed by the ottending physise os the burial-tronsit permit. Then pl by prior ta burial, crematian, or removol, WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMAN (Yes, no, or unknown) (If yes give war or dates of service 18. CAUSE OF DEATH (Enter only one cause per line for (g), (b) and (c) PART I. DEATH WAS CAUSED BY-INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE CAUSE (o) Page 4 may be retained by the hospital or attending physician. 4222 **DUE TO** Conditions, if any, which gave rise to immediate cause (o), DUE TO stating the underlying couse WAS AUTOPS PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(g) PERFORMED? be detoched for use Stote Dept. of Health YES T NO F O FUNERAL DIRECTOR: After this certificate 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Part It of Item 18.) 20g ACCIDENT WAS UNDERLYING [] OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (State) 20c TIME OF INJURY Month, Doy, Year (Eity or fown) (County) Hour a.m. factory, street, office bldg., etc.) Not While at work at work 21. I certify that (I) (this haspital) attended the deceased fram 19 60 director, page 3 shauld should be filed with the and that death accurred at M, fram calses and an the date stated above. saw the deceased alive an 22b DATE SIGNED 22o. SIGNATURE **ATTENDING** STAFF MD. PHYS DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) OHIN 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or 23a BURIAL, CREMATION 23b. DATE THEREOF REMOVAL(Specify) Lincoln Cemetery Frince Georges 250 RECD BY REGISTRAR 24. FUNERAL DIRECTOR, VR A15 (4) 25M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH and 2 OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) COUNTY o. STATE COUNTY -Tracke. MARYLAND the CITY OR TOWN (If outside corporate limits, write RORAL and give nearest town) illed in by ... papers. Pager c, LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS S RESIDENCE within 72 ON A FARM? 1005 YES NAME OF Middle DATE Month completely DECEASED OF DEATH (Type or print) 196 Car 6. COLOR OR RACE 7. MARRIED NEVER MARRIED AGE IF UNDER DATE OF BIRTH (In years IF UNDER 24 HRS Months Doys Hours WIDOWFD DIVORCED and in an 1Do USLA, OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT no most of working life, even if retired) INDUSTRY physician Own home usewise FATHER S NAME MOTHER'S MAIDEN NAME crematian, ar removal, attending phys WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO INFORMANT (Yes_no, or unknown) (If yes give wor or dates of service) yes None 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c)) INTERVAL BETWEEN the burial-transit PART I. DEATH WAS CAUSED BY ONSET, AND DEATH IMMEDIATE CAUSE (o) by Page 4 may be retained by the haspital ar attending physician. 4201 DUE TO signed burial, Conditions, if any, which gave rise to immediate cause (o), DUE TO stating the underlying couse been as the prior to has PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) WAS AUTOPS' YES NO certificate Ь 20o. ACCIDENT WAS UNDERLYING [7] 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 18) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 2Dc TIME OF INJURY Month, Doy, Year 2Dd INJURY OCCURRED 2De. PLACE OF INJURY (Home, form, (City or fown) (County) (Stote) SE SE Hour o.m. Not While factory, street, office bldg., etc.) 19 O FUNERAL DIRECTOR: After of work at work 21. I certify that (1) (this haspital) attended the deceased fram M, from causes and an the date stated above and that death accurred a saw the deceased alive an 220. SIGNATURE DATE SIGNED filed PHYS DIRECTOR PHYS director, page shauld be filed 22d. ADDRESS Rockville, Maryland 22c. PEPISICIAN'S Thibadeau Robert NAME (Type) BURIAL, CREMATION, 23b DATE THEREOI 23c NAME OF CEMETERY OR CREMATORY 23a 23d. LOCATION (City or Town) (County) (Stote) BEMOVAL (Specify) Prince Georges 902 29 Cemetery 24 FUNERAL DIRECTOR 25d REC'D BY REGISTRAR VR A15 (4) 196



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 95290 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceosed lived, if institution. Residence before odm.ssion o. COUNTY o. STATE id completely filled in by the fur emove carban papers. Pages I gny event, within 72 hours after MARYLAND PPINCO TOW TEOMERY b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLENGTH OF STAY IN 16 c. CITY OR FOWN (If outside corporate limits, write RURAL and give nearest town) d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? NO N YES physician and completely fen pleasers remove carban ovol, and the phy event, with NAME OF 4. DATE Doy Year DECEASED OF DEATH (Type or print) 196 SEX 9. AGE (1) years lost birthdoy) IF UNDER 1 YEAR IF UNDER 24 HRS 6 COLOR OR RACE 7. MARRIED NEVER MARRIED Months Dovs Hours WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work done 106 KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11 BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired) **INDUSTRY** COUNTRY? - GENERAL AdmiNISTARTION 14. MOTHER'S MAIDEN NAME signed by the attending phys buriol-tronsit permit. Then p buriol, cremation, or removal IS WAS DECEASED EVER IN U.S. ARMED FORCES? 17 INFORMAN 16 SOCIAL SECURITY NO (Yes, no, or unknown) (If yes give war or dates of service) IB. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c))
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE CAUSE (o) by the hospitol or attending physicion. DUE TO Conditions, if any, which gave (b) rise to immediate couse (a), DUE TO r this certificate has been si detoched for use os the b ife Dept. of Health prior to b stating the underlying cause WAS AUTOPSY PERFORMED? PART (I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D.SEASE CONDITION GIVEN IN PART 1(6) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of Item 18) 20o ACC DENT WAS UNDERLYING [3] OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF NIJRY Month, Doy, Year 20d INJURY OCCURRED 20e, PLACE OF INJURY (Home, farm, 20f (City or fown) (County) (Stote) Hour 'o.m. factory, street, office bldg., etc.) While Not While ot work at work TO FUNERAL DIRECTOR: After 21. I certify that (1) (this hospital) attended the deceased fram 1967, that (1) (we) last be retained and that death accurred at \$250 p.M. fram causes and an the date stated above. saw the deceased arive 22o SIGNATURE 22b DATE SIGNED ATTENDING director, page 3 should be filed v M.D PHYS. DIRECTOR Page 4 may t 22d ADDRESS 22c. PHYSICIAN'S NAME (Type) 230 BURIAL PREMATION 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 23b DATE THEREOF (Stote 250 REC D BY REGISTRAR FUNERAL DIRECTOR 2Sb VR A15 (4) 25M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05291 MEDICAL EXAMINER'S CERTIFICATE OF DEATH STATE DEPT. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY 2, and 3 to PM3. Page a. STATE b. COUNTY Stote Deportment of b. CITY OR TOWN (If outside carparate limits c JENGTH OF STAY IN 1h oxiside corparate limits, write RURAL and give newest tawn) d STREET ADDRESS e IS RESIDENCE INSTITUTION (If nat in haspital, give street address) form ON A FARM? NAME OF Middle Last DATE DECEASED ÖF (Type or print) DEATH icate, writing the word "pending" in pencil in Item 18. Give be farworded to the Chief Medicol Examiner's Office olding S. SEX COLOR OR 7. MARRIED DATE OF BIRTH AGE (In Agors IF UNDER YEAR IF UNDER **NEVER MARRIED** iast birthday) Months Days Haurs hours ofter deoth WIDOWED DIVORCED pages lond2 10a USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT (State or fareign country) during mast af wark ng ite even if retired) **LINDUSTRY** COUNTRY? 764 SELF EMPROYED 13 FATHER'S NAME 14 MOTHER'S MAIDEN NAME HELE WAS DECEASED EVER IN U.S. ARMED FORCES? event within 72 16. SOCIAL SECURITY NO INFORMANT Address (Yes, nar or unknown) (If yes give war or dates of service) 1B CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c) buriol-tronsit cency Acute PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) This certificate should **DUE TO** yno n Carelio Kaseular Disease Candit'ans, if any, which gave rise ta immediate cause (a). DUE TO D stating the underlying cause as a be used PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19 WAS AUTOPSY PERFORMED? removol, FICATION NO K 20g. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 1 of Item 18) 3 should Should PRIMARY C ar CONTRIBUTING C MEDICAL EXAMINER: CAUSE OF DEATH. cremotian, 20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home farm. 20f. (City or town) (County) (State) Hour a.m. foctory, street, office bldg., etc.) Not While at work at wark 21. I certify that I took charge of the remains described obove, held an Autopsy Inspection X Ingury X. moy be retained for FUNERAL DIRECTOR: ond in my apinian funeral director. deoth resulted from: Natural couses X. Accident Suicide . Homicide Undetermined monner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED SIGNATURE prior DEPUTY MEDICAL EXAMINER **EXAMINER'S** Health JOHN M.D. NAME (Type) BALL. Address (Street, city, town, ar caunty) BURIAL CREMATION. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) (State) 500 95H GEMERERY FUNERAL DIRECTOR VR A15ME (5) 6M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 05290 05292 ethin 72 hours after death. and PLACE OF DEATH 2 USUAL RESIDENCE (Where deceosed lived, if institution, Residence before admission), o COUNTY ince Georges o. STATE L COUNTY T MARYLAND The law requires that the death certificate be executed within 24 haurs after by his Pages b CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) write RURAL and give nearest town) Wyattsbille .⊑ d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) papers. d STREET ADDRESS e IS RESIDENCE ON A FARM? filled i 2214 Calver NO D 3 NAME OF DATE OF DEATH farban Middle Month Doy Year DECEASED (Type or print) 19 6 COLOR OR RACE 7. MARRIED AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS NEVER MARRIED lost birthday) Months Doys Hours WIDOWED X DIVORCED burial, crematian, or remayal, and In any 17-1892 7.5 yrs USUAL OCCUPATION (Give kind of work done KIND OF BUSINESS OR RTHPLACE (County & Stote, or foreign country) 12 CITIZEN OF WHAT please INDUSTRY COUNTRY? SALES Man HUNGARY Hecht Co. 13. FATHER'S NAME MOTHER'S MAIDEN NAME TWIESER Dickenschiedt 16 SOCIAL SECURITY NO. 7 INFORMANT Katherine WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give wor or dotes of service Soule same as 578-10-4321 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (t).)
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH death. er death 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) I. PLACE OF DEATH o. COUNTY a. STATE Maryland b. COUNTY Montgomery Montgomery MARYLAND The law requires that the death certificate be executed within 24 hours after b CITY OR TOWN (If autside corporate timits, write RURAL and give nearest town) CLENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 Days Bethesda Bethesda d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS B IS RESIDENCE ON A FARM? completely filled in 5400 Pooks Hill Road Bethesda Silver Spring Nursing Home YES NO 🔀 event, with 3. NAME OF Middle Last 4 DATE Month Day Year First DECEASED OF DEATH April EDA BOSE BREWER 19 67 (Type or print) IF UNDER 24 HRS. S SEX 6 COLOR OR RACE 8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR 7. MARRIED NEVER MARRIED 74 birthdoy) Dovs Hours Nov. 14, 1892 Female Cauc. WIDOWED DIVORCED buriol, cremation, or removal, and in any, 10a USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? IJ. during most of working I fe, even if retired)

Housewife

FATHER S NAME INDUSTRY S. Mass. 14. MOTHER'S MAIDEN NAME Ida Beuhler Herman Bose 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, go, or unknown) (If yes give wor or dates of service) 74405 Ridgeway Ave SOCIAL SECURITY NO. 2-20-1568 17. INFORMANT SOT Scott R. Brewer, Jr. - Chevy Chase, Md. INTERVAL BETWEEN 18 CAUSE OF DEATH (Enter only one couse per line foc.(a), (b), and (c).) buriol-transit ONSET AND DEATH PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) signed by Page 4 may be retained by the hospital or ottending physicion. DUE TO GV/MO Conditions, if any, which gave rise to immediate cause (a). DUE TO stoting the underlying couse O FUNERAL DIRECTOR: After this certificate hos been director, page 3 should be detached for use as the should be filed with the State Dept. of Health priar to 19. WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) MEDICAL CERTIFICATION NO BE 20o ACCIDENT WAS UNDERLYING [205. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20d INJURY OCCURRED 20c. TIME OF INJURY Month, Doy, Year Hour om. foctory, street, office bldg., etc.) Not While 21. 1 certify that (I) (this haspital) attended the deceased fram www. , 196 × to ceprus Carry 26 1961, and that death occurred at 6:05 M, from causes and on the date stated above. sow the deceased alive on... 22b. DATE SIGNED 22a SIGNATURE ATTENDING 22d. ADDRESS 22c. PHYSICIAN S NICOALE NAME (Type) 23d. COCATION (City or Town) 230 BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (County) Burial Specify) 5-1-67 Arlington Natl Cem. Arlington. 25b. REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR 2So. REC'D BY REGISTRAR VR A15 (4) 20 M 1/66 Mintes Judge ROBERT A. PUMPHREY, Bethesda, Maryland



| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 30T W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 1. PLOCK FRAM CERTIFICATE OF DEATH 1. PLOCK FRAM COUNTY CERTIFICATE OF DEATH CERTIFICATE CERTIFICATE OF DEATH CERTIFICATE CERTIFICATE OF DEATH CERTIFICATE COUNTY COUNT |
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| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) A. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) A. STREET ADDRESS G. STREET ADDRESS |
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| Hour a.m. 19 While Not While at work at work factory, street, office bidg., etc.) |
| 21. I certify that (I) (this hospital) attended the deceased from NFC21, 194, to AFR. 18, 196, that (I) (we) saw the deceased alive on AFR 18, 196, and that death occurred at M, from the causes and on the date stated ab 220. SIGNATURE |
| 21. I certify that (I) (this hospital) attended the deceased from \(\begin{align*}{ll} F \in 2\end{align*}, \text{196}, \text{toff} \(\begin{align*}{ll} F \in 2\end{align*}, \text{196}, \text{toff} \(\begin{align*}{ll} F \in 2\end{align*}, \text{196}, \text{toff} \(\begin{align*}{ll} F \in 2\end{align*}, \text{toff} \(\begin{align*}{ll} F \in 2\end{align*}, \text{toff} \(\begin{align*}{ll} F \in 2\end{align*}, \text{toff} \\ \text{22a}, \text{sight} \text{sight} \\ \text{22a}, \text{sight} \\ \text{align*} \\ \text{22a}, \text{sight} \\ \text{align*} \\ \te |
| ATTENDING MED. STAFF DIRECTOR |
| 22c. PHYSICIAN'S NAME (Type) ABERT T. THIBADENU 10CKVILLE MD 20852 23c. BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OF CREMATORY 23d LOCATION (City, town or downty) (State) |
| 236. BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City, town or dounty) (State) |
| 24 FONERAL PIRECTOR ADDRESS, ADDRESS, BEGISTRAR'S SIGNATURE |
| VR A15 (4) Lather Kalters 254 Careal St DATE, PR 2 1 1967 gelienter Judge |



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05293 95295 CERTIFICATE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PLACE OF DEATH PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after dea the ottending physician and completely filled in by the fundation papers. Pages 1 on nation, or removal, and in any event privinin 72 hours after de a. COUNTY o. STATE b. COUNTY Montgomery St. Mary's Maryland MARYLAND c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 Mechanicsville 160 days Bethesda d. STREET ADDRESS e IS RESIDENCE d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ON A FARM? Box #44 YES NO X The Clinical Center, Bethesda, Maryland 3. NAME OF 4 DATE Last Month Doy Year DECEASED OF April 19 67 Yvonne Patricia Briscoe (Type or print) DEATH 9. AGF (In years IF UNDER 1 YEAR IF UNDER 24 HRS 5 SEX 8. DATE OF BIRTH 6. COLOR OR RACE 7. MARRIED NEVER MARRIED lost birthdoy) Months Dovs Hours WIDOWED DIVORCED 13 September 1954 Female Negro 12. CITIZEN OF WHAT 10o USJAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State or foreign country) during most of working life, even if retired) COUNTRY? INDUSTRY USA Student None Maryland 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAMI James A. Briscoe Carolyn Bowman IS WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT The Medical Recordiness 16. SOCIAL SECURITY NO. signed by the ottendii burial-tronsit permit. (Yes, na, or unknown) (If yes give wor or dates of service) The Clinical Center, Bethesda, Maryland None 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN ONSEL AND DEATH PART I. DEATH WAS CAUSED BY: Gram Negative Septicemia IMMEDIATE CAUSE (o) _ Page 4 moy be retained by the hospitol ar ottending physician. DUE TO Conditions, if ony, which gove Acute Leukemia Unknoun (b) rise to immediate couse (a), DUF TO stoting the underlying couse prior to **TO FUNERAL DIRECTOR:** After this certificate has been director, page 3 should be detached for use as the 19. WAS AUTOPS)
PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) CERTIFICATION YES X NO 205. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of Item 18) 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) (City or town) (County) (State) 20e. PLACE OF INJURY (Home, form, 20c. TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED Hour o.m. Not While foctory, street, office bldg., etc.) ot work at work L 21. I certify that (1) (this haspital) attended the deceased fram Oct. 24., 1966, to April 2, 1967, that (4) (we) last saw the deceased alive an April 2) 1967, and that death accurred at 2:25 M, fram causes and an the date stated above. director, page 3 should should be filed with the 22o, SIGNATURE 22b. DATE SIGNED ATTENDING 3 April 1967 PHYS. M.D. DIRECTOR The Clinical Center, National 22c. PHYSICIAN S William R. Levis NAME (Type) Institutes of Health, Bethesda, Md. 23d. LOCATION (City or Town) 23c. NAME OF CEMETERY OR CREMATORY (Stote) 23b. DATE THEREOF 230 BURIAL CREMATION REMOVAL (Specify) 25b. REGISTRAR S SIGNATURE MORGANZA. APRIL 5.1967 JOSEPHS 24. FUNERAL DIRECTOR Milanles Judge VR A15 (4) 1/20 M 1/66 1/2 W. CLARKE MATTINGLEY LEGNARDTOWN, MARYLAND



DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05296 CERTIFICATE OF DEATH on papers Pages I and 2 within 72 haurs after death requires that the death certificate be executed within 24 haurs after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution o. COUNTY a STATE **b** COUNTY omer MARYLAND LENGTH OF STAY IN 16 (CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) outside comparate aimits e IS RESIDENCE NAME OF HOSP TAL OR INSTITUTION (If notion hospital, give street address) d STREET ADDRESS YES NAME OF DATE Year DECEASED OF DEATH (Type or pnnt) and in any even 6. COLOR OR RACE AGE 7 MARRIED NEVER MARRIED last birthday) Months Dovs Hours WIDOWED X DIVORCED 10a JSUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 12 CITIZEN OF WHAT during most of warking life, even if retired) INDUSTRY COUNTRY? colina House wi 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME remayal, 15. WAS DECEASED EVER IN U.S. ARMED FORCES? INFORMANT 16 SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give wor or dates of service) 5 crematian, IB. CAUSE OF DEATH (Enter only one couse per ripe for (o), (b), and (c) signed by the burial-transit burial, cremati PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ONSET AND DEATH DUE TO Conditions, if any, which gove rise to immediate cause (a). DUE TO stating the underlying cause be aetached for use as the State Dept. af Health priar ta has been PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY PERFORMED? NO 20g ACCIDENT WAS UNDERLYING □ 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF NJURY Month, Doy, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, 20f. (City or fown) (County) (State) Not While factory, street, office bldg., etc.) While 21 | certify that (1) (this haspital) attended the deceased from / 1967, that (1) (we) lost Page 4 may be retained TO FUNERAL DIRECTOR: saw the deceased alive on 4 19 67, and that death accurred at_ M, from causes and an the date stated above 220 SIGNATURE 22b DATE SIGNED ATTENDING M.D. DIRECTOR PHYS PHYS 22d. ADDRESS NAME (Type) Raymond O West Silver Springs, Md. 23b DATE THEREOF 23d. LOCATION (City or Town) 230 BURIAL CREMATION. 23c NAME OF CEMETERY OR EREMATORY (County) (Stote) Kernersville Cemetery
ADDRESS 250 REC REMOVAL (Specify) Kernersville April 16, 1967 Forsyth N C Burial
24 FUNERAL DIRECTOR 2So REC'D BY REGISTRAR 25b REGISTRAR'S SIGNATURE VR A15 (4) 25M 1/67 Hyattsville, Md F. Gaschs Sons

MARYLAND STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05297 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death 1. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. COUNTY Montgomery o. STATE Maryland a. COUNTY Montgomery physicion and completely filled in by the full on please, remove corbon papers. Pages 1 MARYLAND b CITY OR TOWN (If outside carparate limits, c. LENGTH OF STAY IN 16 c CITY OR TOWN (If autside carporate limits, write RURAL and give nearest town) corbon papers. Pag ept, within 72 hours Damascus d NAME OF HOSPITAL OR INSTITUTION (If not in haspita, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? 26730 Ridge Rd. 26730 Ridge Rd. YES NO X First 3 NAME OF Middle DATE Month Day Year DECEASED April Laura Gertrude 67 Burns 19 (Type or print) DEATH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 5 SEX 6 COLOR OR RACE B DATE OF BIRTH OFFEND 7. MARRIED NEVER MARRIED last burthday) Manths Hours Female White WIDOWED K March 17,1873 DIVORCED 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or fareign country) 12 CIT ZEN OF WHAT 10a USLA, OCCUPATION (Give kind of work done during most of working life, even if retired) COUNTRY? INDUSTRY puo Purdum. Md. USA 14 MOTHER'S MAIDEN NAME 13. FATHER'S NAME Edward King Julia Burdette 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. Address (Yes, na, ar unknown) (If yes give war ar dates at service) Mrs Aubrey Mullineaux. $I + em_{-2}$ 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)
PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) INTERVAL BETWEEN signed by the buriol-tronsit p DUE TO buriol Conditions, if ony, which gave rise to immediate couse (o), DUE TO stating the underlying couse as the the hospitol or attending O FUNERAL DIRECTOR: After this certificate has been last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 19. WAS AUTOPSY PERFORMED? YES NO [ξ 20a. ACCIDENT WAS UNDERLYING 205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH detoched (IF EITHER, NOTIFY MEDICAL EXAMINER) (State) 20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame, form, (City or town) (County) Haur o.m. factory, street, affice blda., etc.) Nat While at work at wark 21. I certify that (I) (this hospital) attended the deceased from 2 10 , 1950 to 4/10 , 1960 that (I) (will last saw the deceased glive an 4/10 1950, and that death accurred a 2:30 M, from causes and an the date stated above. should 220. SIGNATURE 22b. DATE SIGNED ATTENDING X 4/16/67 M.D. PHYS. DIRECTOR PHYS. 22d. ADDRESS HYSICIAN'S James P. Kerr. M.D. Damascus, Md. NAME (Type) director, should b 23d. LOCATION (City or Town) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (County) (State) 23o. BURIAL, CREMATION, REMOVAL (Specify) Apr. 17,1967 Mt. View Purdum, Md. 24 FUNERAL DIRECTOR ADDRESS Olin L. Molesworth, Damascus, Md. 20 M 1/66



| ا ' نو | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|
| FOR STATE | 95298 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05296 | | | | | | | | |
| HEALITY DEPT. | De COUNTY MARYLAND 2. USUAL RESIDENCE (Where deceosed lived, if institution Residence before admission) a STATE MASS. b COUNTY SUFFOLK | | | | | | | | |
| y detay is ond 3 to PM3 Page | b CITY OR TOWN (If butside or) arate I mits, write RURAL and give reagest town) write RURAL and give reagest town) | | | | | | | | |
| De De da 97 | d. NAME OF HOSP TALOR INSTITUTION (If not, in hospitol, give street oddress) d STREEL DDRESS ON A FARM? YES NO PA | | | | | | | | |
| | 3 NAME OF DECEASED (Type or print) FRANCIS COSEDA COMERON 4. DATE OF DEATH 4-22 167 | | | | | | | | |
| | S S N 6 COLOS ON RAFE 7. MARRIED NEVER MARRIED 18 DATE OF BIRTH 9. AGE (In years IFUNDER 1 YEAR FUNDER 24 HRS Months Doys Hours Min | | | | | | | | |
| n 24 hours o' l in Item 18. er's Office al ges I and 2 w | 10g USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12 CITIZEN OF WHAT COUNTRY? | | | | | | | | |
| d within 24 in pencil in Examiner's Examiner's Fite poges 7 hours ofte | Thomas Cameron 14 Möther's Maiden NAME Mary Finnegan | | | | | | | | |
| | 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO INFORMANT Address 4403 Chr. Struct (Yes, no. jor vinknown) [If yes give war or dotes of service) 26-18-7393 (Donald Compensary) | | | | | | | | |
| rould be executed word "pending" if the Chief Medical rial-transit permit. | 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) INTERVAL BETWEEN O'NSET AND DEATH | | | | | | | | |
| | Canditions, if any, which gove) (b) | | | | | | | | |
| This certificate should tote, writing the word se farwarded to the Chebe used as a burial-tremovol, and in any ev | rise to immediate couse (a). stating the underlying couse (b). (c) | | | | | | | | |
| | PART II OTHER S.GNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE COND.TION GIVEN IN PART I(a) 19 WAS ALTOPSY PERFORMED? YES \(\text{VAS} \) NO \(\text{VAS} \) | | | | | | | | |
| | PERFORMED? YES NO YES N | | | | | | | | |
| MIN the variation of the motion | 20x TIME OF NJJRY Month, Doy, Year While of work of wo | | | | | | | | |
| Se de la | 21. I certify that I took charge of the remains described above, held on Autopsy, Inspect on, Inquiry, ond in my opinion death resulted from: Natural causes Accident, Suicide, Hamicide Undetermined manner | | | | | | | | |
| MEDIT Neose direct etaine to bu | ACTUAL SIGNATURE ACTUAL SIGNATURE ACTUAL SIGNATURE M.D. ASSISTANT MEDICAL EXAMINER 22. DATE SIGNED | | | | | | | | |
| Prior No. | EXAMINER'S VIA - S. R. O. S. A. S. M. O. DEPUTY MEDICA. EXAMINER NAME (Type) 9 (5 Sept. 12 Se | | | | | | | | |
| TO DEPU necessor the fun 5 may TO FUNE Health | 230 BJR AL, (REMATION, 230 DATE THEREOF 23c NAME OF CEMETER (OF CREMATORY 23d LOCAT ON (City or Town) (County) (Stote) Burial—transit 4-24-67 New Swedish Cemetery Worcester, Mass | | | | | | | | |
| VR A15ME (5) 6M 1/67 | 24 FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland DATE APR 28 1967 | | | | | | | | |
| | | | | | | | | | |

MARYLAND STATE DEPARTMENT OF HEALTH



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 35293 requires that the death certificate be executed within 24 haurs after death 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) 1. PLACE OF DEATH Montgomery b. COUNTY MARYLAND b CITY OR TOWN IIf outside comparate limits. C LENGTH OF STAY IN 16 (CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jakoma Park Washington, D. C. days 42 d. STREET ADDRESS IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1211 Kalmia Road YES NO TO Washington Sanitarium and NAME OF Doy Year DECEASED OF DEATH 24 Genevieve Elizabeth Carr April 19 67 (Type or print) 9. AGE (In years I YEAR I IF UNDER 24 HRS SEX 6 COLOR OR RACE B. DATE OF BIRTH IF UNDER 7. MARRIED NEVER MARRIED lost birthdoy) Months Hours Jan 27, 1907 white emale WIDOWED DIVORCED 10a USUAL OCCUPATION (Give kind of work done 13 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT 10b KIND OF BUSINESS OR during most of working life, even if retired) U COUNTRY? Washington, D. C. 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Frank P. Carr Betsy G. Saffell WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT 1211 Kalnia Road, N.W. (Yes, no, or unknown) (If yes give wor or dates of service) 578-28-6017 Mrs. Frank Carr INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c) signed by the buriol-transit p PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate couse (a), DUE TO stating the underlying couse 'O FUNERAL DIRECTOR: After this certificate has been the th last. WAS AUTOPSY PERFORMED? PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) CERTIFICATION YES -NO for 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Year Hour o.m. foctory, street, office bldg., etc.) Not While of work of work 21. I certify that (1) (this haspital) attended the deceased from , and that death accurred at 25200 M, from causes and an the date stated above saw the deceosed alive on_ 196 220 SIGNATURE 22b. DATE SIGNED ATTENDING PHYS. director, puy BURELL M.D. DIRECTOR PHYS. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) 11412 Viers Mill Road, Wheaton, Md. Francis X. Richardson, M. D. 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 230 BURIAL, CREMATION 23b. DATE THEREOF (Stote) Suitland, Maryland Cedar Hill Cemetery Apr 26. 2Sb. REGISTRAR'S SIGNATURE 25o. REC'D BY REGISTRAR VR A15 (4) Pumphrey. DATE A P Ochemia

MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301, W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item #9 Film #G338 CERTIFICATE DEATH death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) the funera a. COUNTY o. STATE b. COUNTY-MARYLAND The law requires that the death certificate be executed within 24 hours after b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 15 c CITY OR TOWN (If outside corporate limits, write RURAL and give, searest town) write RURAL and van papers. Pag within 72 haurs in by d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d STREET ADDRESS e IS RESIDENCE ON A FARM? 2500 40 YES NO T 3. NAME OF Middle First DATE Yenr and completely DECEASED Type or print) DEATH S. SEX IF UNDER 1 YEAR JE UNDER 24 HRS 6. COLOR OR RACE 7. MARRIED NEVER MARRIED DATE OF BIRTH 9 AGE IIn years burnday) Months Dovs Hours WIDOWED DIVORCED un o 10o. USJAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12 CITIZEN OF WHAT 11 BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired) INDUSTRY COUNTRY? 13 FATHER S NAMI 14 MOTHER'S MAIDEN NAME IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT Address (Yes, no_orgigknown) [[If yes give wor or dotes of service] crematian, IB. CAUSE OF DEATH (Enter only one couse per live for (o), INTERVAL BETWEEN signed by the burnal-transit PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) à DUE TO Conditions, if any, which gave 3 rise to immediate couse (a). DUE TO stating the underlying couse has been PART II OTHER SASKIPICANT CONDITIONS CONTRIBUTING TO DEATH SCT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19 WAS AUTOPSY PERFORMED? YES 🗍 NO. PHYSICIAN: 20g. ACCIDENT WAS UNDERLYING [DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port i) of item 18) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (C 'y or fown) (County) (Stote) Hour to.m. Not While foctory, street, office bldg., etc.) While OR ATTENDING of work ot work 10 FUNERAL DIRECTOR: After 4 may be retained by 21. I certify that (1) (this haspital) attended the deceased from 19 to 1967, that (I) (we) los 20 19 saw the deceased alive on and that death accurred at M. from causes and an the date stated abave 22a. SIGNATURE DATESIGNED STAFF PHYS. DIRECTOR M.D. director, page shauld be filed 22c. PHYSICIAN'S NAME (Type) UCC 23c. NAME OF CEMETERY OR CREMATORY 23o. BURIAL, CREMATION, 23b DATE THEREOF 23d LOCATION (City or Town) (County) (Stote) · REMOVAL (Specify) 22/67 Forest Oak lithersburg, " ry_ nd 250. REC'D BY REGISTRAR ADDRESS 24 FUNERAL DIRECTOR VR A15 (4) 25M 1/67 Tunorol Home has ler



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH Item #2b.c & d F 24 hours after death. funeral PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a COUNTY 27 MARYLAND b CITY OR TOWN (If ausside corporate limits, write RURAL and give nearest town) c LENGTH OF STAY IN 16 c. CITY OR TOWN (If gotside carparate limits, write RURA), and give nearest town) Wheatch/ Balto. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) d. STREET ADORESS 4608 Roland Ave IS RESIDENCE ON A FARM? YES NO 1 requires that the death certificate be executed within NAME OF 4. DATE Day Year by the attending physician and completely ronsit permit. Then please remove carbo DECEASED BONTA Type or print' DEATH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS MARRIED **NEVER MARRIED** last birthday) Months Days Hours WIDOWED DIVORCED 10a USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State or fareign country) 12, CITIZEN OF WHAT during most of working life, even if retired)
Hou sewife **INDUSTRY** COUNTRY? Pennsylvania 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME William Jefferis Barnes Ru th Anna Reans 5325 Addres k towne Rd. 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO (Yes ma, ar unknown) (If yes give war or dotes of service Washington, D. C. Mrs. Myra E. Lank signed by the offer buriol-tronsit perm buriol, cremation, o INTERVAL BETWEEN ONSELAND DEATH 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) DUE TO Canditians, it any, which gove rise to immediate cause (o), DUE TO stoting the underlying cause os the prior to this certificate has been WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO 20o. ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20d. INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) (State) 20c. TIME OF INJURY Manth, Doy, Year foctory, street, affice bldg , etc.) Haur a.m. 2). I certify that (1) (this haspital) attended the deceased from 4-14 , 1967, to 4-27, 1967that (I) (we) last 26 19 67, and that death accurred at 2.30 M, from causes and an the date stated above saw the deceased alive an TO FUNERAL DIRECTOR: 22b. DATE SIGNED 22a. SIGNATURE M.D. DIRECTOR director, pay-22d. ADDRESS 22c PHYSICIAN S NAME (Type) 23b DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23a BURIAL (REMATION, (County) (State) REMOVAL (Specify) Friends Burial Grounds Baltimore, Md. 25g. REC'D BY REGISTRAR 25b. REGISTRAR S SIGNATURE 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 05302 requires that the death certificate be executed within 24 haurs after death. by the funeral 2. Pages 1 and 2 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before banness PLACE OF DEATH o. COUNTY **b** COUNTY o. STATE Montgomery MARYLAND Tennessee carban papers. Pages gnt) within 72 haurs affi c LENGTH OF STAY IN 16 b CITY OR TOWN (If outside corporate limits, c. CITY OR TOWN (If autside carparote limits, write RURAL and give nearest town) write RURAL ond give necresi town)
Bethesda (rural 4 days Memphis filled in ! 8. IS RESIDENCE ON A FARM? d. NAME OF HOSP TAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS 3986 Weaver Road NO TE Naval Hospital YES 3. NAME OF 4. DATE First Middle Month Day Year and completely DECEASED dny eyent) Calvin Μ. CHAVTES DEATH April (Type or print) IF UNDER 1 YEAR IF UNDER 24 HRS. S SEX DATE OF BIRTH 9. AGE (In years regradive & 6 COLOR OR RACE 7 MARRIED NEVER MARRIED lost pythdoy) Months Hours November 12.1912 WIDOWED DIVORCED Female Cauc 10a LSUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11 BIRTHPLACE (County & State, or foreign country) during most of warking life, even if refired) INDJSTRY by the attending physician transit permit. Then please crematian, ar remaval, and i Dawson Springs 13. FATHER S NAME 14 MOTHER'S MAIDEN NAME Unknown Unknown Calvin Hunsaker Rose Ferrel IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT Address Tennessee 16. SOCIAL SECURITY NO Memphis (Yes, no, ar unknown) (If yes give wor or dates of service) Mr. Edward J. Chavies. 3986 Weaver Road INTERVAL BETWEEN THE CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

A CLUT D. MISCOCOLUMN signed by the burial-transit p ONSET AND DEATH Acute myocardial infarct IMMEDIATE CAUSE (o) DUE TO Rheumatic aortic stenosis Conditions, if any, which gove nse ta immediate cause (a). DUE TO stating the underlying cause as the has been lost. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(g) YES X TO HOSPITAL OR ATTENDING PHYSICIAN: T Page 4 may be retained by the haspital ar or FO FUNERAL DIRECTOR; After this certificate NO 200 ACC DENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of item 18.) (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or fown) (County) (Stote) 20c. TIME OF INJURY Manth, Day, Year factory, street, office bldg., etc.) Nat While at work April 11 19 67, that Of (we) last 21. I certify that (t) (this hospital) attended the deceased from April 7 19 67 ta saw the deceased glive an April 11 19 67, and that death occurred at 815A M, from causes and on the date stated above 220 SIGNATURE 22b. DATE SIGNED ATTENDING STAFF PHYS. Apr. 13.1967 DIRECTOR PHYS 22d ADDRESS 22L PHYSICIAN S NAME(Type) David R. FOREMAN, M. D. Naval Hospital. Bethesda. Maryland 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) 23a. BURIAL CREMATION. 23b. DATE THEREOF (State) Rock Creek Cemetery Washington. D. C. 4-14-1967 25b REGISTRAR S SIGNATURE 24 FUNERAL DIRECTOR Joseph Gawler & Sonsodress 2So. REC'D BY REGISTRAR Wisconsin Ave., Washington, D. C. VR A15 (4) Miarley Judge 20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 0530 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE 05303 HEALTH DEP PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o COUNTY -Page MARYLAND c LENGTH OF STAY IN 16 outside corparate limits, write RURAL and give nearest town) and 2 with the State Department and PM3. d. STREET ADDRESS IS RESIDENCE ON A FARM? OF HOSPITAL OR INSTITUTION (If not in haspital give street address) forwarded to the Chief Medical Examiner's Office along with farm NO X 3. NAME OF A GOL DECEASED OF DEATH NEVER MARRIED 9 AGE (In years 6 COLOR OR RACE 7. MARRIED 8. DATE OF BIRTH IF UNDER 1 YEAR los birthdoy) Months DIVORCED deoth. WIDOWED 12 CITIZEN OF WHAT 10b KIND OF BUSINESS OR BIRTHPLACE (State or foreign country) lere at G.P.O. COUNTRY? This certificate shauld be executed within 13 FATHER SANAMI 14 MOTHER'S MAIDEN NAME in ony event within 72 hourse pencil Chewnina ary Wyn IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO (Yes, no, or unknown) (If yes give wor or dotes of service) Lester Chewning 18 CAUSE OF DEATH (Enter only one couse per, the for (o), (b), and (c)) . INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: MULTIPLE INTURIES. IMMEDIATE CAUSE (o) the certificate, writing the mord FROM AUTO ACCIDENT Conditions, if any, which gave 3 SUDDEN nse to immediate couse (a), DUF TO stating the underlying couse WAS AUTOPS or removol, PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) CERT FICATION NO. 200 EXTERNAL CAUSE WAS 206 DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port or Part II of tem 18 3 should PRIMARY DO CONTRIBUTING CAUSE OF DEATH Passenger Mi Cor went out of control street Dok cremotian, MEDICAL 20c TIME OF INJURY Month, Day Year 20d NIURY OCCURRED 20e PLACE OF IN.URY (Home, farm, (City or town) Not While at work foctory, street office blag , etc.) 5 may be retained for your O FUNERAL DIRECTOR: Poge of work AdelPhia PrinceGeorge M4 21. I certify that I took charge of the remains described above, held on Autopsy [X], Inspection X and in my opinion Accident 🔀 the funerol director. deoth resulted from Noturol couses . . Surcide Homicide Undetermined monner CHIEF MEDICAL EXAM NER Heolth prior to ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE Old Georgetown Rd NAME (Type) Address (Street, city, town, or county) 23d LOCATION (City or Town) NAME OF CEMETERY OR CREMATORY 23o BURIAL, CREMATION DATE THEREOF (County) RURENOVA (Specify) Fort Lincoln Cemetery Prince Georges Co., Md. 2So REC D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 8434 Georgia Avenue VR A15ME (5) ythanker Junga 6M 1/67 DATAPR ilver Spring.



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 05304 requires that the death certificate be executed within 24 hours after death funeral 1 and ond I. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) p. COUNTY GALIFORNIA b. COUNTY filled in by ...
papers. Pages I was after d MONTGOMERY MARYFAND b. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town)

ROCKVILLE c LENGTH OF STAY IN 15 c. CITY OR TOWN (If autside corparate limits, write RURAL and give negrest town). 2 months STINLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? Potomac Valley Nursing Home 7948 Wentworth Street YES NO . NAME OF First Middle DATE Doy Year DECEASED 28 MERCELIA April 19 67 (Type or print) CHINO DEATH IF UNDER 1 YEAR 5 SEX 9. AGE (In years LIF UNDER 24 HRS 6. COLOR OR RACE B. DATE OF BIRTH 7 MARRIED NEVER MARRIED remark n.any ev last birthday) Manths Days Haurs Female White and in any WIDOWED T DIVORCED August 9, 1888 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State or foreign country) 12. CITIZEN OF WHAT INDUSTRY COUNTRY? Missouri 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME burial, cremation, or remayol, Thomas E. Hicks Tda E. Scofield IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT Address (Yes, no, or unknown) (If yes give war or dates of service) Elbert Chino (son) 325-09-5392 INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one rouse per tine for (o), (b), and (c)) signed by the burral-transit p ONSET AND DEATH PART I. DEATH WAS CAUSED BY. DEPTICEMIA IMMEDIATE CAUSE (a) DUE TO EREBROVASCULAR ALCIDENT Conditions, if any, which gave rise ta immediate cause (a), DUE TO stating the underlying cause ARTERIOSCLEQUSIS, GENERAL Stote Dept. of Health prior to last 50 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPS'
PERFORMED? NO K 20g ACCIDENT WAS UNDERLYING [20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City or fown) (County) (State) O FUNERAL DIRECTOR: After this Not While Haur 'a.m. factory, street, affice bldg, etc) at wark 21 I certify that (1) (this haspital), attended the deceased fram. O HOSPITAL OR ATTEND Poge 4 moy be retained saw the deceased glive on 4/2 4/6 > 19____, and that death occurred at 8 M, fram causes and an the date stated above 22a, SIGNATURE 22h DATE SIGNED **ATTENDING** Ø MD DIRECTOR PHYS director, page should be filed 22c. PHYSICIAN'S 22d ADDRESS NAME (Type) 10401 OLD GERRIETOWN KO 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 230 BUR AL CREMATION, (Caunty) (State) Cremation ium | Washingtonk 250. REC'D BY REGISTRAR | 25b. REGISTRAD Lee's Crematorium 24. FUNERAL DIRECTOR

Washington, D. C.

VR A15 (4) 25M 1/67

Lee Funeral Home



| 2 | 1 | Ite | ems 1.8%21 Fi | Film 390 6-24MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | |
|---|---|---------------|---|--|---|-------------------|--|---|---------------------------|---|
| J | FOR STATE | | 05305 | | MEDICAL EXAMIN | ER'S CI | ERTIFICATE OF | DEATH | 053 | 303 |
| H | EALTH DEPT. | | PLACE OF DEATH o. COUNTY o. CITY OR TOWN II outside write RURAL dnd give neo | corporate line ts, | MARYL | AND . | 2. USUAL RESIDENCE (Whe o. STATE C. CITY OR TOWN (If outside the control of the c | | OUNTY | |
| | death If any ve Pages 1, 2, with form Printer The State Depart | 3. | Wash & | TITUTION (If not in h | Ospitol, give street oddress) Hospita Middle | // | d STREET ADDRESS 1374 Jac | Vor St. | n.W. | e. IS RESIDENCE ON A FARM? YES NO X |
| | 24 havrs after death 1 in Item 18. Give Pages r's Office along with for est Vand 2 with the State office death. | S | (Type or print) SEX 6 COLO hale Wf | antor | ARRIED A TREVER MARRIED DOWED DIVORCED | | 7/16 DATE OF BIRTH -7-83 | 9. AGE (In year | s IF UNDER 1 YE Months Do | 3 1967 EAR IF UNDER 24 HRS. OYS Hours Min |
| | d within 24 haurs in pencl in Item 1 Examiner's Office File pages Vand 2 7 haurs after deat | dur | USJAL OCCUPATION (Give kming most of working ite, even it Shoemaker FATHER'S NAME | d of work done f retired) | 10b. KIND OF BUSINESS OR INDUSTRY Self-amploye | ō l | 11 BIRTHPLACE (State or 1) Taylu MOTHER'S MAIDIN NAM Carmela | | 12 CITIZE | N OF WHAT JRY? |
| | be executed with pending" in per ef Medical Exan nsit permit. File nt within 72 hau | | WAS DECEASED EVER IN U.S. A s, no, or unknown) (If yes give 120) | e war or dates of servi | 1577-48-0896 | 11 | ORMANT DSpital | 7 | rd, | INTERVAL BETWEEN |
| | the ward "pe the ward "pe to the Chief burial-transit in any event | | PART I. DEATH WAS CA | AUSED BY MEDIATE CAUSE (o) DUF TO (b) O). (DUF TO | Acute bronc | hopne | umonia, Bi | lateral | | ONSET AND DEATH |
| | winker: This certificate, writing I should be farwarded r files. 3 should be used as a should be used as | CERTIFICATION | 2Do EXTERNAL CAUSE WAS PRIMARY □ or CONTRIBUTIN | CONDITIONS CONTRI | BUTING TO DEATH BUT NOT RELA | | | | | 19 WAS AUTOPSY PERFORMED? YES NO |
| | arcal Examiner: This certives execute the certificate, writter Page 4 should be farwared for your files. ECTOR: Page 3 should be used burial, cremation, ar remaval, | MEDICAL C | 2Dt. TIME OF INJURY Month Hour a.m. p.m | 19 | 2Dd INJURY OCCURRED While Not While of work of work the remoins described obo | foctory | OF INJURY (Home, form, , street, office bldg., etc.) | 2Df (City or town | | y) (Stote) |
| • | ME pleas dire dire DIR | | deoth resulted from | _ | | Suicide | CHIEF MEDICAL EXA M D ASSISTANT MEDICAL | , Underermined | | 22. DATE SIGNED |
| | TO DEPUTY ME necessary, pleas the funeral dire 5 may be retain 10 FUNERAL DIRI Health priar to | 230 | EXAMINER'S NAME (Type) BEL BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE THEREOF | | M.D ERY OR CRI | | Vision (City of Vision (City of Vision) (Vision) (City of Vision) | | 3, /967 ounty) (State) |
| | VR A15ME (5) 6M 1/67 | 1 | rancisJ.Co | Collen- | 2239008 | · · | 2So. REC'D BY | REGISTRAR 2Sb. | REGISTRAR'S SIGN | VATURE |



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05306 CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. COUNTY a STATE b. COUNTY Montgomery MARYLAND montgomery b CITY OR TOWN (If autside corporate limits, c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 write RURAL and give nearest fown) Spring hours Tahoma d NAME OF HOSPITAL OR INSTITUTION (If pat in haspital, give street address) d STREET ADDRESS IS RESIDENC filled i ON A FARM? YES NO IX NAME OF Middle DATE Doy Year completely DECEASED 1967 May FARDC (Type or print) DEATH S SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED 8 DATE OF BIRTH AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. remove last birthday) Months Days Hours WIDOWED X DIVORCED lashile Famale 10o. USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 12 CITIZEN OF WHAT 11 BIRTHPLACE (County & State, or fare-an country) ease COUNTRY? physician (during most of warking life, even if retired) INDUSTRY the deoth certificate a. Kota Housewite South 13. FATHER'S NAME 큡 14. MOTHER'S MAIDEN NAME cremation, or removal, James elma 15 WAS DECEASED EVER IN U.S ARMED FORCES? 16. SOCIAL SECURITY NO 17 INFORMANT Addressy (Yes, no, ar unknown) (If yes give wor or dates of service Washing Danifarium 18 CAUSE OF DEATH (Enter only one couse per line for (a), PART I. DEATH WAS CAUSED BY: (b), and (c).) INTERVAL BETWEEN buriol-transit puriol, cremati ONSET AND DEATH IMMEDIATE CAUSE (o) DUE TO Canditions, if any, which gave rise to immediate cause (a). DUE TO stating the underlying cause d for use os the last. WAS ALTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) has NO X certificote 20g ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) OR CONTRIBUTING CAUSE OF DEATH etoched (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20x TIME OF INJURY Manth, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame, farm, (City or town) (County) (State) Hour o.m. factory, street, affice bldg., etc.) While Nat While at wark 21. I certify that (I) (this haspital) attended the deceased from sections. 1966. to ahril 24, 1967, that (I) (we) last be retoined saw the deceased alive an april 2419/7, and that death accurred at 15 5 M, from causes and on the date stated above. TO FUNERAL DIRECTOR: 220 SIGNATURE DATE SIGNED **ATTENDING** M D PHYS PHYS PHYSICIAN'S NAME (Type) 23a BURIAL CREMATION 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Tawn) (County) (State) DI REMON'AL (Specify) 11/28/67 Glenwood Cemetery washington. 25a REC'D BY REGISTRAR 24 FUNERAL DIRECTOR 25b REG STRAR S S GNATURI VR A15 (4) 25M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 05307 requires that the death certificate be executed within 24 haurs after death funeral 1 and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) o. STATE T o. COUNTY b. COUNTY 51.0 MARYLAND COL campletety filled in by the faces are a Pages b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) arban papers. Pag nt, within 72 haurs OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRE IS RESIDENCE ON A FARM? YES NO D NAME OF Middle DATE Lost Month Doy Year DECEASED (Type or print) 19 (0 DEATH S SEX AGE (In years 1 YEAR IF UNDER 24 HRS MARRIED DATE OF BIRTH IF UNDER гетаме, NEVER MARRIED last birthday) Months Dovs Hours ar remaval, and in any WIDOWED DIVORCED signed by the attending physician and burial-transit permit. Then please rem KIND OF BUSINESS OR 10o. USUAL OCCUPATION (Give kind of work done 10b. 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? 13. FATHER S NAME 14. MOTHER'S MAIDEN NAME Address Sec Item 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) (If yes give wor or dates of service 500 burial, crematian, 1B. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c) INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gove rise to immediate couse (a). DUE TO has been sise as the the priar to the stating the underlying couse Page 4 may be retained by the haspital ar attending lost. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) WAS AUTOPSY PERFORMED? far use (Health p NO NO certificate YES -20o ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item IB.) OR CONTRIBUTING CAUSE OF DEATH State Dept. af detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (State) Hour o.m. factory, street, office bldg., etc.) While Not While of work TO FUNERAL DIRECTOR: After ot work 21. I certify that (1) (this haspital) attended the deceased fram. . 1967, that (I) (we) lost directar, page 3 shauld should be filed with the and that death occurred at 8 saw the deceosed alive an M, from couses and on the date stoted obove. 22n. SIGNATURE 22b. DATE SIGNED ATTENDING STAFF PHYS. M.D. PHYS DIRECTOR 22d ADDRESS 22c. PHYSICIAN'S NAME (Type) > 8641-23o. BURIAL CREMATION 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) Removal (Specify) Brick Church Cemetery Montgomery 4-12-1967 FUNERAL DIRECTOR ADDRESS 2So. REC'D BY REGISTRAR VR A15 (4) 211 M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05308 CERTIFICATE OF DEATH OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after-death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) o. COUNTY o. STATE b. COUNTY ely filled in by the fane ban papers. Pages 1 a , within 72 haurs after de MUNTGOMERY MARYLAND b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give negrest tawn) mo- 20 da. A. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS IS RESIDENCE ON A FARM? NO T YES NAME OF Middle DATE Year refinave carban Doy and completely DECEASED 24RG-VERITE 19 607 (Type or print) DEATH IF UNDER 1 YEAR IF UNDER 24 HRS 5 SEX 6. COLOR OR RACE AGE (In years 7 MARRIED NEVER MARRIED last birthdoy) Months Hours WIDOWED DIVORCED 10o USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12 CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY There se thurst 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME cremation, ar remayal, WAS DECEASED EVER IN L.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMAN (Yes, no, or unknown) (If yes give wor or dates of service INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b) and (c) signed by the obvious burial-transit p PART I DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gave rise to immediate couse (o), DUE TO stating the underlying couse has been be detached far use as the State Dept, af Health priar ta lost. WAS ALTOPSY PERFORMED? PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) NO 20o. ACCIDENT WAS UNDERLYING [20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port , or Port II of item 1B) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER! MEDICAL 20e PLACE OF INJURY (Home, form, (County) (Stote) 20c TIME OF INJURY Month, Doy, Year 20d INJURY OCCLERED (City or fown) Hour p.m. foctory, street, office bldg., etc.) Not While 1967, that (1) (we) lost 21. I certify that (I) (this haspital) attended the deceased from . ta director, page 3 should should be filed with the 1962, and that death accurred at 10 30M, fram causes and on the dote stated above. O FUNERAL DIRECTOR: saw the deceased alive on. 220. SIGNATIURE **ATTENDING** MD PHYS. DIRECTOR 22d ADDRESS "PHYSICIAN" NAME (Type) 23b. DATE THEREOF BURIAL, CREMATION, wirt Oak REMOVAL (Specify) FUNERAL DIRECTOR VR A15 (4)



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 35309 CERTIFICATE OF DEATH OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) o. COUNTY Montgomery b. COUNTY Montgomery MARYLAND b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c LENGTH OF STAY IN 16 c CITY OR TOWN (If outside carparate limits, write RURAL and give negrest tawn) 20 days Silver Spring 5 d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS e is RESIDENC ON A FARM? The Clinical Center, Bethesda, Maryland 8105 Eastern Avenue YES NO A NAME OF Middle First 4. DATE Lost Manth Day Year DECEASED (Type or print) 1967 Cohen April Bertram Jay DEATH S SEX IF JNDER 1 YEAR IF UNDER 24 HRS B. DATE OF BIRTH 9 AGE (In years 7. MARRIED NEVER MARRIED X last birthday) Months Hours Nov. 25, 1942 Male WIDOWED DIVORCED 10o USUAL OCCUPAT ON (Give kind of work done 10b, KIND OF BUSINESS OR 11 BIRTHPLACE (County & Stote, or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired) COUNTRY? INDUSTRY Interviewer Employement Washington, D.C. USA 13 FATHER'S NAME 14 MOTHER'S MAIDEN NAME or removol, Jack Cohen Florence Waxman 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. The Medical Recordress (Yes, no, or unknown) [(If yes give wor or dates of service) The Clinical Center, Bethesda, Maryland 216-40-7826 cremotian, 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c))
PART I DEATH WAS CAUSED BY. INTERVAL BETWEEN
ONSET AND DEATH
O MINUTES Respiratory failure IMMEDIATE CAUSE (o) DUE TO signed l Conditions, if any, which gove Lymphosarcoma vear rise to immediate cause (a), DUE TO stoting the underlying couse PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 WAS AUTOPSY PERFORMED? NO F this certificate 20o ACC DENT WAS UNDERLYING [20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, farm, (City or town) 20c TIME OF INJURY Month, Doy, Year (County) (Stote) factory, street, office bldg, etc.) Not While TO FUNERAL DIRECTOR: After of work ot work 21. I certify that (1) (this haspital) attended the deceased fram April 9 , 1967, to April 29, 1967, that (4) (we) last saw the deceased alive an April 29 1967, and that death accurred at 11:40M, fram causes and on the date stated above. TO HOSPITAL OR ATTEND Page 4 may be retained saw the deceased alive an April 29 22o SIGNATURE 22b DATE SIGNED STAFF April 30, 1967 DIRECTOR 22d. ADDRESS The Clinical Center, National 22c. PHYSICIAN'S NAME (Type) Leonard H. Brubaker, Institutes of Health, Bethesda, Md. 23b DATE THEREOF 23: NAME OF CEMETERY OR CREMATORY 230 BURJAL, CREMATION, 23d LOCATION (City or Town) (County) REMOVAL (Specify) King David Mem. Gar. Falls

ADDRESS 501-14 th St 250. RECD BY REGISTRAR

IS NW, Wash. DC, 200 LOMAY 2 1 4/30/67 Falls Ch. 24 FUNERAL DIRECTOR VR A15 (4) 25M 1/67 Bernard Danzansky & Sons



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 05310 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PLACE OF DEATH o. COUNTY a. STATE b. COUNTY campietely filled in by the form MARYLAND MONTGOMERY VIRGINIA c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b CITY OR TOWN (if outside corporate fimits, CLENGTH OF STAY IN 16 write RURAL and give nearest town) requires that the death certificate be executed within 24 hours BETHESDA (rural <u>ATEXANDETA</u> carbon papers. ent/within 72 ha e. IS RESIDENCE d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS ON A FARM? YES [NO X 1108 PAIMER PLACE NAVAL HOSPTTAL NAME OF Month First Middle 4. DATE Day Year DECEASED (Type or print) DEATH VINCENT WITI-TAM COLLINS APRTI TE UNDER 24 HRS S SEX 9. AGE (In years 6 COLOR OR RACE 7 MARRIED XX NEVER MARRIED remove Jost birthday) Manths Hours CAUC MALE WIDOWED DIVORCED 12 CITIZEN OF WHAT 10o USJAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) ease during most of warking life, even if retired) INDUSTRY COUNTRY? US NAVY LYNCHBURG. VA USA 14. MOTHER'S MAIDEN NAME 13. FATHER S NAME removal, ELLA WILLIAMS EDWARD RANDOLPH COLLINS 15 WAS DECEASED EVER IN J.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address 1108 PAIMER PLACE (Yes, no, or unknown) (If yes give war at dates of service) signed by the atter burial-transit perm burial, cremation, a BLTIVE CAROL M. COLLINS ALEXANDRIA 250 05 3/101 VIRCINTA INTERVAL BETWEEN IB. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c)) ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (6) CARDIAC ARREST DUE TO Canditions, if any, which gave rise to immediate couse (a), DUE TO stating the underlying cause O FUNERAL DIRECTOR: After this certificate has been ‡ lost. PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 19. WAS AUTOPS PERFORMED? MEDICAL CERTIFICATION YES 1 NO F 205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) 200 ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e, PLACE OF INJURY (Hame, form, (City or tawn) (County) (State) 20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED factory, street, affice bldg., etc.) Hour o.m. Not While of work of work 21. I certify that (1) (this haspital) attended the deceased from 21 APRIL , 1967, to 21 APRIL 1968, that (1) (we) last saw the deceased alive an 21-APRIL 1967, and that death accurred at 5:40 MM am causes and an the date stated obave. 22b. DATE SIGNED 22a, SIGNATURE ATTENDING STAFF PHYS. DIRECTOR M.D. 21 PHYS 22d. ADDRESS 22c PHYSICIAN'S NAVAL HOSPITAL DR. MC USN NAME (Type) 230. BURIAL, CREMATION, REMOVAL (Specify) BUR LAL 23d LOEATION (City or Town) NAME OF CEMETERY OR CREMATORY (Stote) 23b DATE THEREOF (County) ARIANNA INE CAEST GARDIAS 0 RIOA W.W. CHAMBERS CO., ADDRESS, 2Sb. 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 1400 CHAPIN ST. NW WASHINGTON DEC

MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 0531: 05309 CERTIFICATE OF DEATH PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) Montgome Ry within 72 haurs after MARYLAND HOSTGOME+4 b CITY OR TOWN (If autside carparate limits, write/RURAL and give neafest tawn) C LENGTH OF STAY IN 16 CLITY OR TOWN (If outside carparate limits, write RURAL and give nearest town) GERMANTOWN filled in papers. STREET ADDRESS d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Box 76 . (20767 completely fi NAME OF 4 DATE Month Day DECEASED OF DEATH (Type or print) S. SEX 6 COLOR OR RACE 9. AGE (In years IF UNDER 1 YEAR 7. MARRIED NEVER MARRIED B. DATE OF BIRTH reprieve (last birtheay) MARCH 22, 1880 WIDOWED IX DIVORCED 1Da USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or fareign country) 12 CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? Chicago . Illinois Housewife 13 FATHER'S NAME Fr nk Patterson 14. MOTHER'S MAIDEN NAME burial, crematian, ar remayal, 17. INFORMANT 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO (Yes, na, ar unknown) (If yes give war ar dates of service) 54 5206T 10 Margaret G. Riggs -Daughter- s me 1B. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY. INTERVAL BETWEEN ONSEL AND DEATH signed By the burial-transit p IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise ta immediate cause (a), DUE TO use as the l stoting the underlying cause PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 200 ACCIDENT WAS UNDERLYING [206, DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Part II of item 183 OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e. PLACE OF INJURY (Hame, form, (C'y ar town) (County) 20c, TIME OF INJURY Manth, Day, Year Not While Haur 'a.m. factory, sweet, affice bldg., etc.) at work

e IS RESIDENCE ON A FARM?

YES NO X

IF LINDER 24 HRS

WAS AUTOPS PERFORMED? NO

(County)

Mcharles Judge

25b REGISTRAR S SIGNATURE

urryland

Prince George

1967

250. REC'D BY REGISTRAR

(State)

21. I certify that (I) (this hospital) attended the deceased from 20/1416/1, 1962, to 6 Cyrick, 1967 that (I) (we) last saw the deceased alive of 5 Cyrick 1967, and that death accurred at 12/14M, from causes and an the date stated above 22o. SIGNATURE 22b. DATE SIGNED M.D DIRECTOR 22c. PHYSICIAN'S T. Montgomery Ave., Roc'ville L. NAME (Type) 23b DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Tawn) 23a. BURIAL, CREMAT ON REMOVAL (Specify)

Cedar Hill

4/6/67

Tyson heeler duneral lone 1511 Kock. Pike

25M 1/67

requires that the death certificate be executed within 24 haurs

director, page Shauld be filed



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH o. STATE **F. COUNTY** Md. MARYLAND CLENGTH OF STAY IN 16 Baltimore

05310

05312 death. puo PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. COUNTY Montgomery hin 72 hours after b. CITY OR TOWN (If outside carparate limits. c. CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) write RURAL and give nearest tawn) þ Kensington e IS RESIDENCE ON A FARM? pallers. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS filled i 130 G.A. Windson Mill Road Kensington Gardes Wrsing Home YES NO KE 3. NAME OF Middle 4 DATE Month Lost Dov Year ompletely DECEASED April 21. 19 67 Mardory Ann Contant (Type or print) or removal, and in any event, DEATH S SEX 6. COLOR OR RACE 8 DATE OF BIRTH AGE (in years IF JNDER 1 YEAR IF UNDER 24 HRS 7. MARRIED **NEVER MARRIED** last birthdoy) Months Hours Femala White WIDOWED X April 27,1903 DIVORCED Ferri gud 10b KIND OF BUSINESS OR 12 CITIZEN OF WHAT 10g. USUAL OCCUPATION (Give kind of work done 13. BIRTHPLACE (County & State, or foreign country) ease during most of working life, even if retired) INDUSTRY COUNTRY? attending physician termit. Then please U.S.A. Housewife New York 13 FATHER S NAME 14. MOTHER'S MAIDEN NAME Patton Richard Stack Frances 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT Address 16. SOCIAL SECURITY NO (Yes, no, or unknown) (If yes give war or dates of service Hospital Records cremation, 18. CAUSE OF DEATH (Enter only one couse per line for/(d),#(b), fand (c)/ INTERVAL BETWEEN signed by the burial-transit p PART I. DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o) DUE TO buriol, Conditions, if any, which gove (b) rise to immediate couse (a), DUE TO stoting the underlying couse as the lost. (c) WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) CERTIFICATION use YES NO this certificate ō 20o ACCIDENT WAS UNDERLYING □ 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c. TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or fown) (County) (Stote) Hour o.m. foctory, street, office bldg., etc.) Not While at work of work **DIRECTOR:** After pe 70 21. 1967, that (1) (we) last 21 | certify/hat (1)(this tiospilal) attended the deceased fram (1) 1966 to 42 m 1967, and that death accurred at 5:26 PM, from causes and on the date stated above. saw the **de**ceased 22b. DATE SLENED 22o. SIGNATU r, page 3 be filed M.D PHYS DIRECTOR. 22d ADDRESS PHYSICIANYS FUNERAL NAME (Type) NW director, should be 230 BURIAL CREMATION. 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d, LOCATION (City or Town) (County) (State) REMOVAL (Specify) 22,1967 Cedar Hill Cemetery Suitland Md. April ADDRESS 24. FUNERAL DIRECTOR

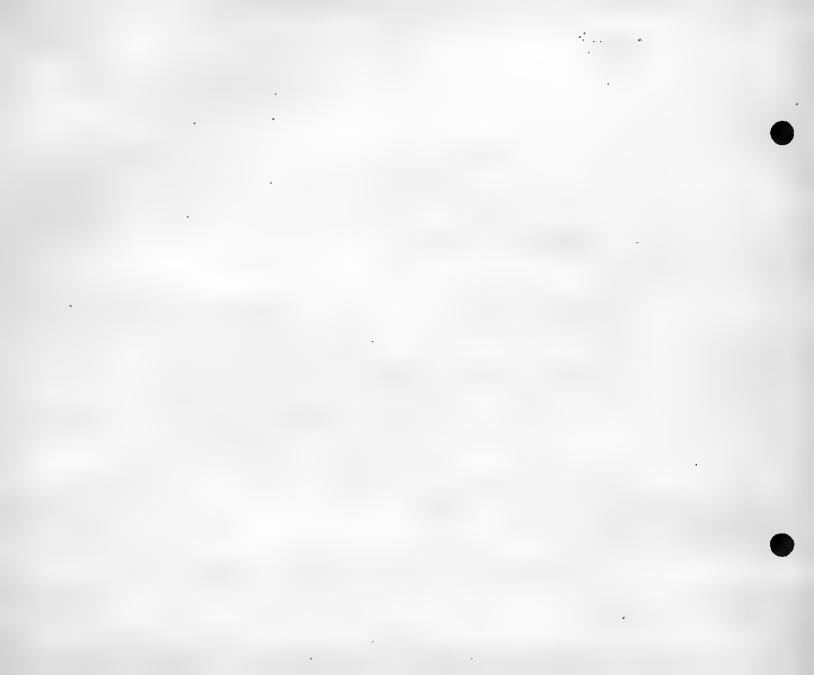
Page 4 may be retained by the hospital or attending physician. 2 **VR A15 (4)** 25M 1/67

executed within 24 hours

PHYSICIAN: The law requires that the death certificate be

250. REC'D BY REGISTRAR BOAPR 2 5 19 Robert E. Wilhelm Funeral Home 4308 Suitland Suitland Md







Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Items #2b & 7 Film #G387 death. requires that the death certificate be executed within 24 haurs affer death l and the attending physician and campletely filled in by the funeral sit purmit. Then please remave carban papers Pages I and 1. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmiss on) O. COUNTY ON TGO MERY o. STATE b. COUNTY . MONTEDINGRY MARYLAND t. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b. write RURAL and give necrest town) LUER SPRING papers hin 72 ha d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) d STREET ADDRESS B IS RESIDENCE 1028 OSPITA NIVERSITY KLUD. NO K 1205 YES NAME OF 4. DATE Middle Lost Month Dov Year DECEASED R5. STHER ORRIGAN HPRIL 19 6 event. (Type or print) DEATH 6 COLOR OR RACE IF UNDER 1 YEAR IF UNDER 24 HRS S. SEX 7. MARRIED NEVER MARRIED DATE OF BIRTH AGE (In years last bigthdoy) Months Dovs Hours 1-16-1900 In any WIDOWED M DIVORCED 10b, KIND OF BUSINESS OR 12 CITIZEN OF WHAT 1Do USUAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (County & State, or foreign country) during most of working life even if retired) COUNTRY? Baltimore. Sookkeener yout. Good 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME ward Webster Hattie M. Foxwell oxwel. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17. INFORMANT Address (Yes, no, ar unknown) (If yes give war or dates of service) -1028 Universi Helen F. Campbell 215-44-8543 cremation. 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c))
PART I. DEATH WAS CAUSED BY: LATERVAL BETWEEN burial-transit INANITI IMMEDIATE CAUSE (o) signed by physician. DUE TO METASTATIC CARCINOMA MOS Conditions, if ony, which gove rise to immediate couse (a). DUE TO stating the underlying couse as the Page 4 may be retained by the haspital ar attending O FUNERAL DIRECTOR: After this certificate has been CARCINOMA last WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMED? for use NO YES 200 ACCIDENT WAS UNDERLYING 205 DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port 1 or Port II of item 18.) OR CONTR.BUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) Dept. 2Dt. TIME OF INJURY Month, Doy, Year Hour o.m. 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) factory, street, office blda., etc.) Not While certify that (i) (this hospital) attended the deceased from 1104 shauld and that death occurred at 213 AM, from couses and on the date stated above say the deceased alive on APR 220. SIØNATURE STAFF PHYS. DIRECTOR M.O PHYS r, page 3 be filed ADDRESS PHYSICIAN'S LEONA NAME (Type) 06 director, shauld 23d LOCATION (City or Town) 23c. NAME OF CEMETERY OR CREMATORY 230 BURIAL CREMATION, 23b. DATE THEREOF (County) REMOVAL (Specify) Sincoln Cemetery PALACE GOAGGA CO EGISTRAR - 256. REGISTRAR'S SIGNATURE APDRESS Georgia Avenue 2So. REC'D BY REGISTRAR VR A15 (4) rcharles 20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05316 CERTIFICATE OF DEATH The law requires that the deoth certificate be executed within 24 hours ofter deoth PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) a STATE land No taomery Montgonery MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 16 Wheaton uears d STREET ADDRESS IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2100 Arcola Avenue 2100 Arcola Avenue NO 🔀 YES NAME OF Middle 4. DATE Lost DECEASED Robert Humbreus Cox April (Type or pnnt) DEATH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS S SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH lost buthdoy) male white Oct 2, 1906 ond in ony WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) COUNTRY? Mer Truland Corn Davidsonville, Md. 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME James Thomas Cox May E. Hwishreys attending permit. The 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT Arcola Aveine permit. (Yes, no, or unknown) (If yes give wor or dotes of service) Nellie U. 578-03-2084 Cox 1B. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED 8Y: INTERVAL BETWEEN the signed by the burial-transit ONSET AND DEATH IMMEDIATE CAUSE (o) Page 4 may be retained by the hospital or ottending physician. 4201 DUE TO Conditions, if any, which gave) (b) nse to immediate cause (a), DUE TO stating the underlying cause DIRECTOR: After this certificate has been PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPS'
PERFORMED? OR ATTENDING PHYSICIAN: (Internature of injury in Port I ar Port II af item 18.) 200 ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c TIME OF INJURY Month, Day, Year Hour am. Not While foctory, street, office bldg , etc.) 19 of work at work 21. I certify that (I) (this hospital) attended the deceased from. and that death agreed at A.M. from/causes and an the date stated above saw the deceased alive on. 22o. SIGNATURE 22b DATE SIGNED MED DIRECTOR STAFF PHYS. M.D. director, page 3 should be filed v 22d. ADDRESS TO FUNERAL MAME (Type) (County) 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23o. BURIAL CREMATION. 23b. DATE THEREOF REMOVAL (Specify) Suitland 250 REC'D BY REGISTRAR 24 FUNERAL DIRECTOR VR A15 (4) 25M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH

| | 0531 | 17 | | CERTIFIC | ATE O | F DEATH | | | 0 | 5315 | |
|-------------------------------|--|--|-----------|------------------------|--------|--|-----------------|-----------------------------------|---------------------------|-----------------------|-----------------|
| Ī | PLACE OF DEATH | | | | 2. | USUAL RESIDENCE (| Where dece | ased lived, if institution | n Residence be | fare admissio | ٦), |
| | o. COUNTY Mor | ntgomery | | MARYLAI | ND | o. STATE Virg | inia | b. COUN | ^{IY} Fairf | ax | V |
| | b CITY OR TOWN (If | autside caroarate limits | | LENGTH OF STAY IN I | lb c | | | irate limits, write RUR | | | |
| | Bethe | give nearest town) | | 36 days | | McLean | | | | | |
| | | . OR INSTITUTION (If not in | _ | | - 11 | STREET ADDRESS | | | | e IS RESID ON A FA | ENCE PM2 |
| | The Clinic | cal Center, | Bethes | da, Md. 200 | 014 _ | 7804 Timo | n Dri | ve | | | NO [3] |
| 3 | NAME OF DECEASED | First | | Middle | | Last | 4 DATE | | | Day Yea | |
| L | (Type or print) | Keit | | Charles | | Culp | DEAT | | | | 67 |
| 5 | | | MARRIED _ | NEVER MARRIED | _ | ATE OF BIRTH | | 9 AGE (In years last birthday) | IF JNDER I YEA Months Day | | 24 HRS. Min. |
| | Male | | WIDOWED |] DIVORCED [| | y 26, 196 | | 4 Y/5 | | | |
| de | ia USUAL OCCUPATION : pring mast of working li Child | (Give kind at work done ite, even if retired) | I DO KIND | OF BUSINESS OR STRY | 11 | BIRTHPLACE (County | | foreign country) | 12 CITIZEN COUNTR | OF WHAT | |
| | G FATHER'S NAME | | | | 114 | Virginia MOTHERS MAIDEN | | | USH | b. | |
| | Joe C. Ct | ıln. | | | | Norma C. | | ın | | | |
| | | IN U.S. ARMED FORCES? | 16.500 | TAL SECURITY NO | | | | l Recording | | D/ | 003 |
| () | res, na, ar unknawn) :{ | If yes give war ar dates of se | ervice) | | | | | | | | 0014 |
| - | NO NO | ATH (Fotor only one couse | No. | | THE | GIIIICai | OBITE | er, Bethes | | INTERVAL BETY | WEEN |
| | PART I DEATH | 18 CAUSE OF DEATH (Enter only one couse per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable septicemia | | | | | | | | | EATH |
| | IMMEDIATE CAUSE (a) Probable Septicemia | | | | | | | | | 7 44,7 13 | |
| | Conditions, if any, | which gove) (b) | Pneum | nonia | | | | | 1 | 2 days | |
| | rise to am mediate cause (o), Stating the angledying cause DUE TO | | | | | | | | | | , |
| | lost (c) Acute Lymphatic Leukemia | | | | | | | | | 2½ year | rs |
| 堂 | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) | | | | | | | | | | PSY D2 |
| CERTIF CATION | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19 WAS AUTOPSY PERFORMED? YES NO | | | | | | | | | | |
| ET I | 200 ACCIDENT WAS UNDERLYING 200 DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part it of Item 18.) | | | | | | | | | | |
| | | AEDICAL EXAMINER) | | | | | | | | | |
| MEDICAL | 20c. TIME OF INJUI Hour a.m. | RY Manth, Day, Year | 20d IN3U | RY OCCURRED 20 | | INJURY (Home, form treet, affice bldg , etc.) | | (City or town) | (County) | (5 | State) |
| ~ | p.m. | | at wark L | at work L | | | | . 15 4 | | | |
| should be filed with the Stat | 21 I certify that Mixithis haspital) attended the deceased from March 10 , 1967, to April 15 , 1967, that M (we) los saw the deceased alive an April 35 47 48 49 49 40 40 40 50 51 52 53 54 55 56 57 58 59 59 50 50 51 52 53 54 55 56 57 58 59 50 5 | | | | | | | | | | |
| | 220 SIGNATURE 22b DATE SIGNED | | | | | | | | | | abave |
| | Y Y Y | Man I | The | m | | ATTENDING PHYS | MED DIRECTOR | STAFF FEE | | ril 196 | 57 |
| | 22c PHYSICIAN'S | | - | | | | | | | | |
| / | NAME (Type) | Myton | J. Lev | rin, MD | | Institute | s of | nical Cen Health, B | ethésda | . Mary | lan |
| 23 | Bo BURIAL, CREMAT OF | N, 235 DATE THERE | OF | 23c NAME OF CEMETER | | | | LOCATION (City or Tow | | | tate) |
| | REMOVAL (Specify) Burial | April L | 9,1967 | Pine Cres | t | | Lit | tle Rock | Arkan | 222 | |
| | 24. FUNERAL DIRECTOR | 110ac 11/2 | Zom | ADDRES 901 | | airfume. REC | BY REGIS | TRAR 250 REC | SISTRAR'S S GNA | TURE | |
| 1 | Arlington | Funeral Hom | | Arlingto | n .Va | . ARR | 191 | 967 | 1 | 0 | |

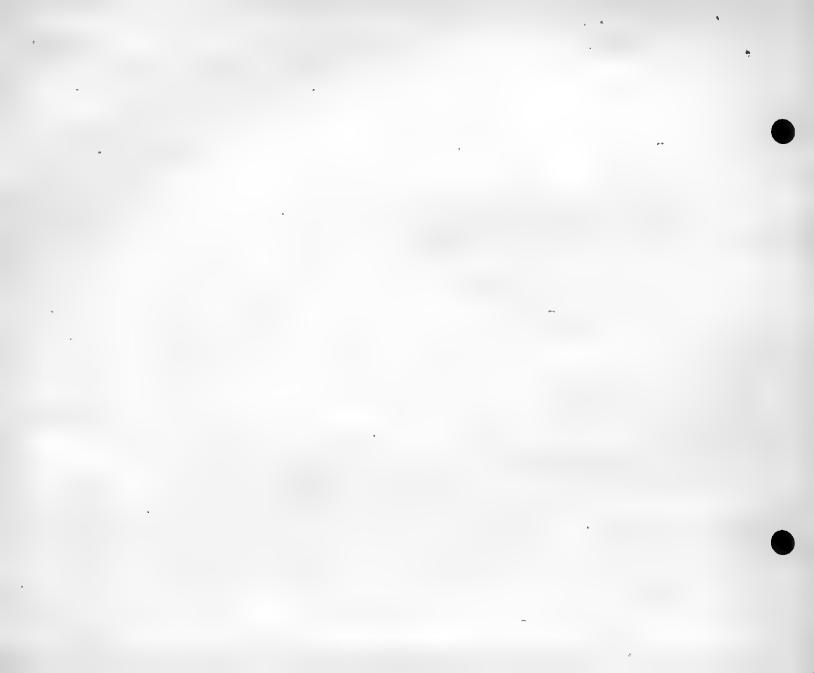


MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W, PRESTON STREET, BALTIMORE, MARYLAND 21201 05318 MEDICAL EXAMINER'S CERTIFICATE OF DEATH PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) · COLNTY Montgomery b COUNTY Montgomery Maryland MARYLAND b CITY OR TOWN (If outside carporate limits, c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c LENGTH OF STAY IN 1b 2, L. PM3 Silver Spring D.O.A. d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS IS RESIDENCE ON A FARM2 ie certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, should be forworded to the Chief Medical Examiner's Office along with form StateD 2005 Holy Cross Hospital Cascade Rd., Give Pages NO K 3 NAME OF Middle 4 DATE lost DECEASED Cummins 24, April, 67 Carl E. OF (Type or print) DEATH S SEX 7 MARRIED ST AGE (In years lost birthday) 6 COLOR OR RACE B. DATE OF BIRTH 1914 IF UNDER 1 YEAR IF UNDER 24 HRS NEVER MARRIED Months White 28, Apr. 3660 Male any event within 72 hours after deoth WIDOWED DIVORCED 10b KIND OF BUSINESS 10a USUAL OCCUPATION (Give kind of work done 11 BIRTHPLACE (Stote or foreign country) 12 CITIZEN OF WHAT during most of working life even if retired) reti COUNTRY? This certificate should be executed within 24 USA Colorado 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME James E. Cummins (Decd) Margaret Ingweisen (Decd) 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 17 INFORMANT 16 SOCIAL SECURITY NO (Yes, no, or unknown) (If yes give war or dotes of service) Maryon Lucille Cummins 2005 Cascade Sil Spr 579-52-6461 ves INTERVAL BETWEEN IB. CAUSE OF DEATH (Enter only one couse per line for (a), (b) and (c).) PART I DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o) writing the word DUE TO Conditions, if ony, which gove rise to immediate couse (a). DUE TO stoting the underlying couse be used removal, PART I OTHER SIGN FICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NA. DISEASE CONDIT ON GIVEN IN PART 1(0) WAS AUTOPSY CATION PERFORMED? please execute the certificate, NO IX 20b DESCR BE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of tem 1B.) 3 should 0 PRIMARY Or CONTRIBUTING CAUSE OF DEATH (City or town) 20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (home, form, (Stote) Hour o.m. foctory, street, office bldg., etc.) Not While DIRECTOR: Poge ot work Inspection 7 21. I certify that I taak charge of the remains described above, held an Autopsy [7], Inquiry , and in my opinion Natural causes Accident deoth resulted from Homicide the funeral director. Suicide Undetermined manner CHIEF MEDICAL EXAMINER **ACTUAL** 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE FUNERAL 1-24-67 DEPUTY MEDICAL EXAMINER Address (Street, city, town, or county) CRYMATORY 23d LOCATION (City or Town) BURIA CREMATION, 50 BUREMOVA (Specify) Arlington Nat'l Cemetery Arlington. 250 REC D BY REGISTRAR VR A15ME (5) 6M 1/67 Pumphrey. Inc. Silver Spring, Md.



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05313 CERTIFICATE OF DEATH offer death. law requires that th∏ death certificate be ≡xecuted within 24 haurs after death USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission PLACE OF DEATH o COUNTY Montgomery o. STATE b. €OUNTY Mary Land Mont gomery
c CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) MARYLAND c LENGTH OF STAY IN 15 b. CITY DR TDWN (If autside corporate limits, write RURAL and give nearest tawn) Kensington mos. Bethesda d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? Bethesda-Silver Spring Nursing Home 10225 Kensington NO 3 YES I 3 NAME OF campletely fi 4 DATE Year DECEASED ANGELA DAVIS DASSORI DEATH April (Type or print) AGE (In years IF UNDER I YEAR 6 COLOR OR RACE DATE OF BIRTH S. SEX 7. MARRIED NEVER MARRIED attending physician and camparents. Then please remove last birthday) Manths Haurs Dec.16.1877 white WIDOWED DIVORCED Female ar remaval, and in an 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

NOUSCWIFC TOB KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, ar foreign country) 12. CITIZEN OF WHAT INDUSTRY COUNTRY? Maine HISA home 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME JOHN JACKSON DAVIS MARGARET TWOMEY 16. SOCIAL SECURITY NO. 17 INFORMANT Address 15. WAS DECEASED EVER IN U.S. ARMED FORCES? Wash. (Yes, no, or unknown) (If yes give war or dates of service Frederic Dassori 3000 Conn. no none burial, crematian, INTERVAL BETWEEN ONSET AND DEATH 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c),
PART I. DEATH WAS CAUSED BY: signed by the burial-transit p IMMEDIATE CAUSE (o) ar atteming physician. DUE TO Conditions, if any, which gave rise to immediate couse (a). DUE TO stating the underlying cause far use as the Health priartal has been 19. WAS AUTOPSY PERFORMED? PART II, OTHER SIGNIFICANT CONDITIONS CONCRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a). YES O FUNERAL DIRECTOR: After this certificate 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Part II of item 18.) 20o. ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e, PLACE OF INJURY (Hame, farm, (Stote) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20f. (City or town) (County) Haur o.m. factory, street, office bldg., etc.) Not While atwark 196-7, that (1) (***) last 2). I certify that (!) (the cosperal) attended the deceased from (964 - to alu 30 1967, and that death accurred at a PM from causes and an the date stated above. saw the deceased alive an 22b. DATE-SIGNED 22n. SIGNATUJE **ATTENDING** M.D. DIRECTOR director, page shauld be filed 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) 11125 Rockville Pike.Rockville.Md 23d. LOCATION (City or Town) 23c. NAME OF CEMETERY OR CREMATORY (Caunty) (State) 23g BURIAL, CREMATION 23b DATE THEREOF New York Greenwood Cemetery Brooklyn. 2So. REC'D BY REGISTRAR 25b. REGISTRAR S SIGNATURE VR A15 (4) BETHESDA, MARY LANDOM PUMZH RE



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05318 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o STATE Kentucky COUNTY **b** COUNTY Montgomery MARYLAND physician and campletely filled in by the fen please remave carban papers. Pages aval, and in amy event, within 72 hours afte b CITY OR TOWN (If outside cornorate limits. c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest tawn) write RURAL and give nearest town)
Bethesda (rural) 177 days Lexington d. STREET ADDRESS d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) B IS RESIDENCE ON A FARM? Naval Hospital 304 South Hanover Ave YES NO F 3. NAME OF Middle Last First Day Year DECEASED (Type or print) John DAVTS eveny Malcolm DEATH Apri] IF UNDER 1 YEAR S. SEX 6 COLOR OR RACE 8. DATE OF BIRTH 9. AGE (n years IF UNDER 24 HRS 7. MARRIED NEVER MARRIED birthdoy) Months Haurs Aug. 30, 1906 remaval, and in any DOWED DIVORCED Male Cauc 11. BIRTHPLACE (County & State, or foreign country) Too USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT COUNTRY? USA during most of wear ng its even if retired) INDUSTRY Morganfield, Kentucky 13 FATHER'S NAME 14 MOTHER'S MAIDEN NAME Virginia Clements Thompson Bennett Davis 17. INFORMANT C-9. Frankfort Address Kentucky 35 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, na, ar unknown) (If yes give war or dates of service) Mrs. Alice M. Davis. 333 East 4th St., APT 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c)) ONSET AND DEATH I-transit PART I. DEATH WAS CAUSED BY. Gastro-intestinal hemorrhage signed by burial-trans IMMEDIATE CAUSE (o) Approx. DUE TO Conditions, if ony, which gave Duodenal ulcer, chronic intestinal obstruction 3 weeks rise to immediate couse (a), DUE TO stating the underlying cause O FUNERAL DIRECTOR: After this certificate has been the Carcinoma of the bladder with carcinomatosis WAS AUTOPS'
PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) YES THE NO 200 ACC DENT WAS UNDERLYING [205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e, PLACE OF INJURY (Home, form, 20f. (City or town) (Stote) 20c. TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED (County) factory, street, office bldg., etc.) Not While of work ot wark þ 2). I certify that (4) (this haspital) attended the deceased fram Oct. 18 , 19 66, to April 13, 19 67, that (4) (we) last saw the deceased alive on April 13 1967, and that death accurred at 1212 M, fram causes and on the date stated abave. 22b. DATE SIGNED 22a SIGNATURE 13 April 1967 directar, page 3 shauld be filed v M.D. DIRECTOR PHYS. 22d ADDRESS PRYSICIAN ! /NAME (Type) James L. Snyder, M. D. Naval Hospital, Bethesda, Md. 23b DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 23o. BURIAL, CREMATION, (County) (State) REMOVAL (Specify) Arlington National Arlington Virginia 4-14-1967 25b. REGISTRAN'S SIGNATURE Joseph Gawler & Sonsoress 25g. REÇ'D BY REGISTRAR 24. FUNERAL DIRECTOR VIII A15 (4) 5130 Wisconsin Ave., N.W., Washington, D.C. III0 M 1/66



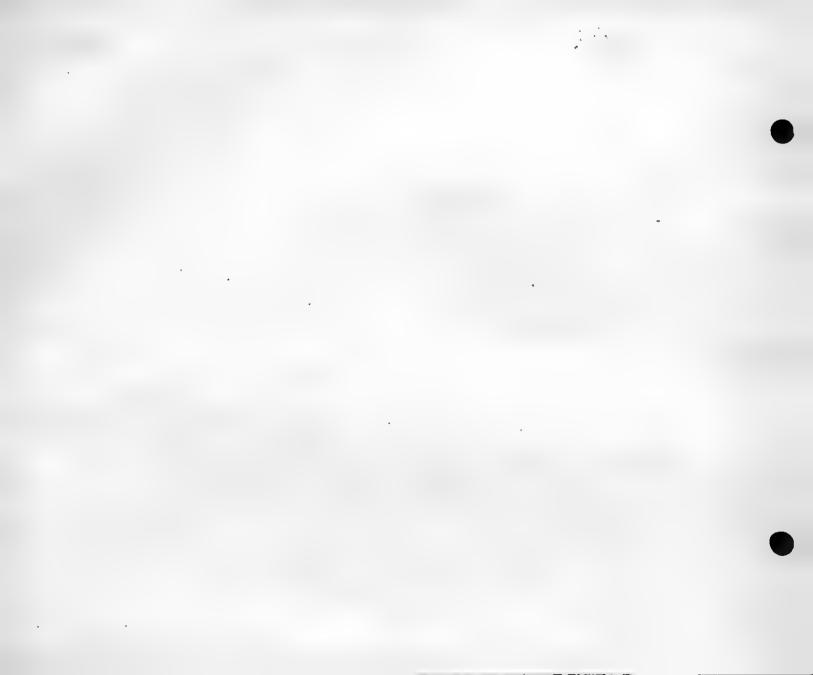
| Items 18-21 Film 388 5-11-MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
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| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYL | AND 21201 | | | | | | | | | |
| 05321 MEDICAL EXAMINER'S CERTIFICATE OF DEATH | 05319 | | | | | | | | | |
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| | 100 Montgomery | | | | | | | | | |
| b CITY OR TOWN (If outside corporate limits, c LENGTH OF STAY IN 1b c CITY OR TOWN (if outside corporate limits, write RUR) | AL and give nearest town) | | | | | | | | | |
| Silver Spring lhr Germantown | | | | | | | | | | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS | # IS RESIDENCE ON A FARM? | | | | | | | | | |
| Hely Cress Hespital Rt #2 | YES NO | | | | | | | | | |
| | Day Year | | | | | | | | | |
| (Type or print) Joseph Hayes Davis DEATH 4 | 7 1967 | | | | | | | | | |
| | Months Dovs Hours Min | | | | | | | | | |
| Male White WIDOWED DIVORCED 1/30/23 44 \$30Cyrs | | | | | | | | | | |
| dur na most of working life even if ratired INDISTRY | 12 CITIZEN OF WHAT COUNTRY? | | | | | | | | | |
| Painter Paint Resoville, Virginia | USA | | | | | | | | | |
| ALL A. C. | | | | | | | | | | |
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| "ITTO THE TOTAL OWN PICT. | | | | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per one for (a), (b), and (c) } | INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
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| nse to immediate course (n) | | | | | | | | | | |
| storing the underlying cause | | | | | | | | | | |
| | 19. WAS AUTOPSY | | | | | | | | | |
| AND IN OTHER SIGNIFICANT CONDITIONS CONTRIBUTION OF THE SERVING TO THE SERVINGS DISEASE CONDITION GIVEN IN MARK 1(0) | PERFORMED? | | | | | | | | | |
| TO STEPNAL CALISE WAS 2006 DESCRIPTION INVIDENCE PORT OF FRANCE OF | YES NO | | | | | | | | | |
| PRIMARY Mor CONTRIBUTING D Deceased, driver, collided head-on with | auto | | | | | | | | | |
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| SIGNATURE THE EVANDED TO | 1 . Da 1010 | | | | | | | | | |
| NAME (Type) DELDEN K. KEAP M.D. Adder Adequitors or country yo | ul 1,/76/ | | | | | | | | | |
| | in) (County) (Stole) | | | | | | | | | |
| Relabilite, | Virginia | | | | | | | | | |
| TO THE TOTAL PROPERTY OF THE PARTY OF THE PA | STRAR SAIGNA VELLER | | | | | | | | | |
| Varner E. Pumphrey, Inc. Silver Spring, Maryland DAR! N 11 1001 | 00 | | | | | | | | | |
| | PLACE OF DEATH COUNTY CO | | | | | | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item #1c Film #G3 1 10.000727 pc OF DEATH CERTIFICATE 05320ely filled in by the funeral barr papers. Pages 1 and 2 within 72 hours after death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY b. COUNTY Columbia MARYLAND CITY OR TOWN (If outside prograte limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 outside carporate limits, write RURAL and give nearest town) CITY OR TOWN (IF 24 haurs Ton IS RESIDENCE ON A FARM? NAME OF HOSPITAL OF INSTITUTION (If not in hospital, give street address signed by the attending physician and campletely filled burial-transit permit. Then please remaye carbor pape NO S YES requires that the death certificate be executed within NAME OF DATE (Type or print) OF DEATH and in any event IF UNDER 24 HRS S SFX AGE 7 MARRIED **NEVER MARRIED** Hours eb WIDOWED DIVORCED 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT FATHER'S NAME 14. MOTHER S MAIDEN NAME burial, cremation, ar remaval, 17. INFORMANT WAS DECEASED EVER IN J.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dates of service en The Ider No 18. CAUSE OF DEATH (Enter only one couse per line for (p), (b), and (c) ONSEL AND DEATH PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) Page 4 may be retained by the haspital ar attending physician. 331X DUE TO Conditions, if any, which gove rise to immediate couse (a), DUE TO stoting the underlying couse O FUNERAL DIRECTOR: After this certificate has been be detached far use as the State Dept. af Health priar to last. PART IL OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED ID THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) WAS AUTOPSY PERFORMED? CERTIF CATION NO 20o, ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18, OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (State) 20c. TIME OF INJURY Month, Doy, Year Hour o.m. foctory, street, office bldg., etc.) Not While ot work of work 21. I certify that (1) (this hospital) attended the deceased from 3 shauld and that death occurred at 12524M, from causes and on the date stoted above sow the deceased alive an. 220. SIGNATURE **ATTENDING** PHYS. DIRECTOR director, page 3 should be filed v M.D. 22d ADDRESS 8218 Wisconsin Avenue 22c. PHYSICIAN S NAME (Type) 23d_LOCATION (Cuty or Jown) Long Island, NAME OF CEMETERY OR CREMATORY (Stote) BURIAL CREMATION 23b. DATE THEREO! (County) Long Is am aica Buriat Brettanist New York Mt. Olivet Cemetery am **ADDRESS** FUNERAL DIRECTOR Maryland Bethesda. VR A15 (4) 20 M 1/66



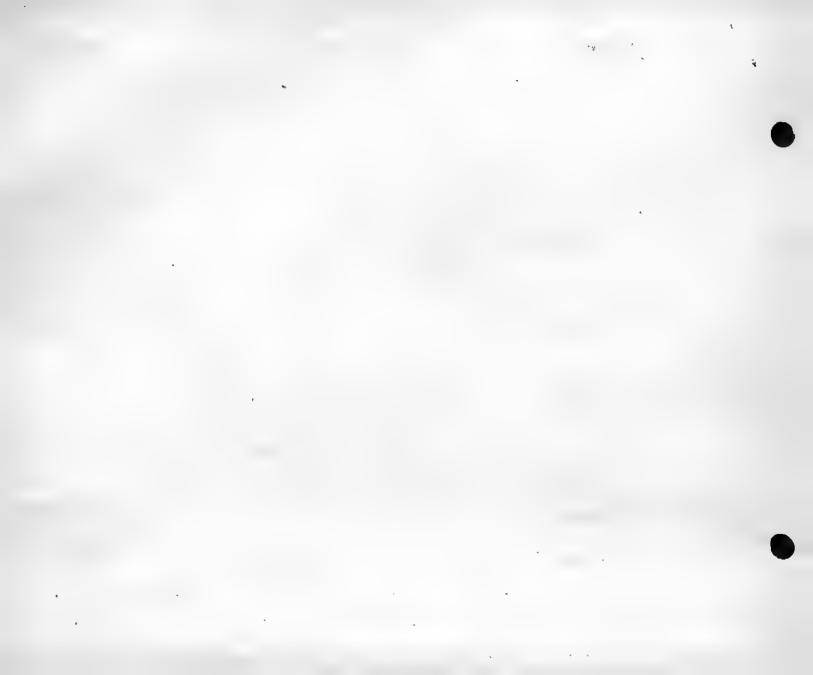
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 05323 he law requires that the death certificate be executed within 24 haurs after death 2 USUAL RESIDENCE (Where deceosed lived, if institution Residence before admission) PLACE OF DEATH Montgomery a. COUNTY MARYLAND remove carban papers. Pages on any event, within 72 hours after and campletely filled in by the remove carban papers. Pages b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) Gaithershurg Gaithersburg 10vrs d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? 00 YES 🗔 NO 12" 16 Maryland Ave 3. NAME OF Middle Lost 4 DATE Month Day Year First DECEASED DFATH 19 (Type or print) Willard Demory April Maie IF UNDER T YEAR AGE (In years IF UNDER 24 HRS S SEX 6 COLOR OR RACE DATE OF BIRTH 7. MARRIED NEVER MARRIED lost birthdoy) Months Days Hours DIVORCED WIDOWED White Jan 11th Female 12 CITIZEN OF WHAT 10o JSUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) COUNTRY? during most of working life, even if retired) INDUSTRY House Wife 1111 Lovettsville, Va 14 MOTHER'S MAIDEN NAME 13 FATHER S NAME Laura J. Spring Charles IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) (If yes give wor or dates of service William L. Demory, Gaithersburg, Md. burial, crematian, INTERVAL BETWEEN ONSET AND DEATH CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c),) signed by the burial-transit p PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) ozanares be retained by the haspital or attending physician. DUE TO Conditions, if any, which gove rise to immediate cause (a), **DUE TO** stoting the underlying couse O FUNERAL DIRECTOR: After this certificate has been director, page 3 should be detached far use as the should be filed with the State Dept. of Health priar ta WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO NO 🖂 205. DESCRIBE HOW INJURY OCCURRED, (Enter noture of injury in Port I or Port II of item 1B.) 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Month, Day 20d INJURY OCCURRED 20s. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) foctory, street, office bldg., etc.) Hour o.m. Not While ot work of work director, page 3 shauld be shauld be filed with the Stat 21 | certify that (1) (this haspital) attended the deceased fram_ ta 19 66, and that death occurred at 10 PM, from causes and an the date stated above saw the deceased alive an 22b. DATE SIGNED 22o. SIGNATURE ATTENDING M.D DIRECTOR 22d. ADDRESS 22c PHYSICIAN S Roclineles 1105 NAME (Type) 23o BURIAL, CREMATION, 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) REMOVAL (Specify) Lovettsville Lovettsville Union VR A15 (4) 20 M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 05325 requires that the death certificate be executed within 24 hours after death within 72 hours after death 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) PLACE OF DEATH a. COUNTY COUNTY-MARYLAND b. CITY OR TOWN c. LENGTH OF STAY IN 16 carporate limits, write RURAL and give newest town) filled in l d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS ON A FARM? NO R 3. NAME OF Doy ⊕ carbon First Middle Lost DATE Month Year completely DECEASED RUTH (Type or print) DEATH event 1F UNDER 24 HRS (In yeors 1F JNDER I YEAR S. SEX 6 COLOR OR RACE 7. MARRIED NEVER MARRIED DATE OF BIRTH lost birthday) Months Days Hours er WIDOWED DIVORCED Ba KIND OF BUSINESS OR 12, CITIZEN OF WHAT 10a, USUAL OCCUPATION (Give kind of work done 10b. 11. BIRTHPLACE (County & State, or fareign country) attending physician of ond !! during most of working life, even if retired)
Housevite INDUSTRY COUNTRY? 13. FATHER S NAME 14. MOTHER'S MAIDEN NAME buriol, cremation, or removal, 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) [(If yes give wor or dotes of service) 16. SOCIAL SECURITY NO. 17. INFORMANT CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c),) INTERVAL BETWEEN ONSET AND DEATH buriol-tronsit PART I DEATH WAS CAUSED BY. Cerebual ANOXIA IMMEDIATE CAUSE (a) hrombosis Left Internal Carotid Artery Conditions, if any which gove ase to .mmediate couse (a), DUE TO stating the underlying couse Atherosci evosis of Health prior to hos been for use as the WAS AUTOPS' PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) AEDICAL CERTIFICATION Hone NO X O FUNERAL DIRECTOR: After this certificate 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH detoched (IF EITHER, NOTIFY MEDICAL EXAMINER director, page 3 should be detache should be filed with the State Dept 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City or lawn) (County) (State) 20c. TIME OF INJURY Month, Day, Year Hour a.m. Not While foctory, street, affice bldg., etc.) ot wark be retained by , 1966 , to 17 April . 19<u>67,</u> that (I) (we) last 21. I certify that (1) (this hospital) attended the deceased fram JAN 15 saw the deceased alive an 16 April 1967, and that death accurred at 7:35 AM, from causes and on the date stated above 22b. DATE SIGNED 220. SIGNATURE STAFF M.D. DIRECTOR PHYS. PHYS 22d. ADDRESS 22c PHYSICIAN'S NAME (Type) Stanley M. Bialek. M. D 8218 Wisconsin Ave 23c NAME OF CEMETERY OR CREMATORY 23b DATE THEREOF 23d. LOCATION (City or Town) 23a. BURIAL, CREMATION REMOVAL (Specify) St. Mary's Cemetery 4-20-67 Hanover, Penna. 2Sb. REGISTRAR'S SIGNATURE ADDRESS 2Sa. REC'D BY REGISTRAR 24 FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 PUMPHREY, Bethesda, Maryland DAMPR 2



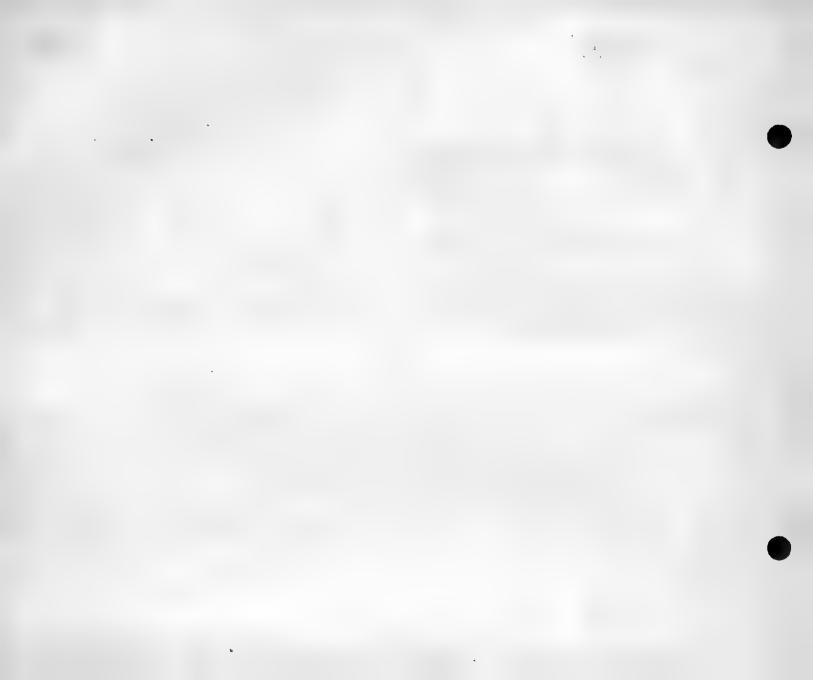
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE O

05324

| 21 B | | 95326 | CERTIFICATE OI | F DEATH | OUDGE |
|--|---------------|---|--|---|--|
| | 1 | O. COUNTY NEWTGOMERY | 1 0 | USUAL RESIDENCE (Where deceased lived, b. STATE 1) 05 HIND FOR D. C. | if institution Residence before admission) b. COUNTY |
| Pages Pages ours aff | | b. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town) Silver | C. LENGTH OF STAY IN 16 C. C. | TTY OR TOWN All autside carporole limits, | write RURAL and give nearest town) |
| papers. Paritin 72 haurs | | d. NAME OF HOSPITAL OR INSTITUTION (If not in h | nospital, give street address)// d. S | STREET ADDRESS 3 1 1 1 + h | e is residence on a farm? YES \(\square\) NO \(\square\) |
| 는 E 등 | 100 | NAME OF First DECEASED (Type or print) MARY | | ACOLO BENIII | Month Doy Year 7 P.R. L 22 19 67 |
| まる | | F WHITE WI | IDOWED DIVORCED 54 | TE OF BIRTH 9. AGE (In last bin 7 26, 1879 57 38 | thday) Months Doys Hours Min. |
| physician and co | d | 00. USUAL OCCUPATION (Give kind of work done louring most of working) to even it estired) leace of the state | INDUSTRY. | BIRTHPLACE (County & State, or fareign coun | 12. CITIZEN OF WHAT COUNTRY? |
| ph) | | John Gardiner S WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. 17 INFOR | MOTHER'S MAIDEN NAME | Address |
| attending permit. Th ian, ar remi | | (Yes, no, or unknown) (If yes give wor or dates of servi | ice) | | 1 Address A. L. |
| signed by the ath burial-transit pen burial, crematian, | | PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (o) DUE TO | full (d.) | y Corin | ONSET AND DEATH |
| | | Conditions, if ony, which gove isse to immediate cause (a), stating the underlying cause DUE TO | | • | |
| as been as the priar to | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIB | BUTING TO DEATH BUT NOT RELATED TO THE TER | RMINAL DISEASE CONDITION GIVEN IN PAR | T I(o) 19 WAS AUTOPSY PERFORMED? |
| rificate has been a for use as the af Health priar to | CEDTIESCATION | 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH | 20b DESCRIBE HOW INJURY OCCURRED (Enter | noture of injury in Port I or Port II of ite | YES NO C |
| this cert detached e Dept. a | MED CAL C | 20c TIME OF INHERY MONTH POLYTON | While Not While factory, str | INJURY (Hame, Form, reet, office bldg , etc.) 20f. (City or | town) (County) (Stote) |
| ECTOR: After this cell should be detache with the State Dept. | | 21. I certify that (I) (this haspital) saw the deceased alive an | of work of work of the deceased from | , 1965, ta22 (th accurred at 2: 404M, from | causes and on the date stated abave |
| | | 226.) SIGNATURE | BUILDER MD PI | HYS DIRECTOR DEPT | AFF 226 DATE SIGNED 4-22-67 |
| director, page shauld be filed | = | 22c. Physician's Name (Type) | ANDA-LL, MD | 22d ADDRESS 3001 V902 | gyTen NW. |
| direct shau | | 23b. DATE THEREOF REMOVAL (Specify) | 23c NAME OF CEMETERY OR CREMA | | ., , |
| A15 (4) im 1/67 | | 24 FUNERAL DIRECTOR - The Stendar | the sy Georgia for y | APR 2 7 1967 | Illiantes Judge |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the haspital or attending physician. VR A1: 25M 1



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH law requires that the death certificate be executed within 24 haurs after death. signed by the attending physician and campletely filled in by the funeral burial-transit permit. Then please remave carbon papers. Pages Land PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) **b** COUNTY MARYLAND mondagemere OR TOWN (In autside carparate finits t. LENGTH OF STAY IN 1b c CITYTOR TOWN If outside corporate limits, write RURAL and give nearest town) please remave carbon mapers. Pag I, and ip any event, within 72 hours d. STREET ADDRESS e. IS RESIDENCE NAME OF HOSPITAL OR INSTITUTION (Mont in hospital, give street address) YES NO NAME OF Middle First Last Doy Year OF DEATH DECEASED 23 196 (Type or print) man 9. AGE (In years IF UNDER 6. COLOR OR RACE 7 MARRIED NEVER MARRIED last birthday) Months Days Haurs WIDOWED DIVORCED Oo. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT INDUSTRY lass 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Walter C. Bullock Elise Avery 15 WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, 14 @ unknown) (If yes give xpcor dates of service) 17 INFORMANT Address 16 SOCIAL SECURITY NO William F. Ditman Same as #2 006-34-7 18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c), PART I DEATH WAS CAUSED BY: INTERVAL BETWEEN burial-transit ONSEL AND DEATH lanoma IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gave rise to immediate cause (a), DUE TO stating the underlying cause Page 4 may be retained by the haspital ar attending has been far use as the last 19. WAS AUTOPSY PERFORMED? YES NO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) TO FUNERAL DIRECTOR: After this certificate 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20g ACCIDENT WAS UNDERLYING [7] OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, (City or town) (Stote) 20c. TIME OF INJURY Month, Day, Year (County) Haur o.m factory, street, office bldg., etc.) Nat While at work 1966, ta . 1967 that (1) (we) last 21. I certify that (1) (this haspital) attended the deceased fram. 1967, and that death accurred at 10PM, from causes and on the date stated above. saw the deceased alive an 22b. DATE SIGNED 22a, SIGNATURE MED. DIRECTOR ATTENDING director, page 3 shauld be filed v M.D. PHYS. 22d. ADDRESS 22c. PHYSICIAN S NAME (Type) G. Lennard Gold. M.D. 8641 Colesville Rd., Silver Spring, Md. 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23a BURIAL, CREMATION (County) (State) Cremation Loudon Park Cemetery Maryland 250. REC'D BY REGISTRAR SIGNATURE 24 FUNERAL DIRECTOR
J.T. Stansbury ADDRESS 6411 Windsor Mill Rd. VR A15 (4) 1967 20 M 1/66



| r I | te | ms 18&21 Fi Divisio | | | | | PARTMENT OF I W. PRESTON STR | | , MARYLAND | 21201 | |
|--|-----------------|---|---|-------------------------|---------------------------------|------------------|--|--------------------------------------|---|-----------------------------|-------------------------|
| FOR STATE | | 05328 | | MED | CAL EXAMIN | ER'S | CERTIFICATE (| OF DEATH | | 05321 | 3 |
| HEALTH DEPT. | 1. | PLACE OF DEATH O. COUNTY Montgoi | mery | | MARY | land . | 2 USUAL RESIDENCE o. STATE Mary | (Where deceosed lived Land | , if institution; Ri b. COUNTY Mo | ontgomer | lmission) |
| | | b. CTY OR TOWN (foutsid write RURAL and give n | e corporate limits | \$, | c LENGTH OF STAY I | y lo | C EITY OR TOWN (If a | utside carporate limits | , write RURAL on | d give neorest to | wn) |
| Departity of the state of the s | | d name of hospital or ii | , | | ive street oddress) | | d. STREET ADDRESS | | | e. I | RESIDENCE IN A FARM? |
| | | Holy Cr | oss Hosp | pital | | | 555 | Chayer Ave | nue | YES | |
| deo ve Po | 3. | NAME OF DECEASED (Type or print) | Peter | rst | Middle L. | Doe | rflein | 4. DATE OF DEATH AP | Month ril 26 | Doy | Year 19 67 |
| 18. Gir | 5. | | OR OR RACE | 7. MARRIED 3 WIDOWED | NEVER MARRIED DIVORCED | | ay 10, 1896 | lost b | n yeors IFU irthdoy) Man O yrs | | JNDER 24 HRS. |
| | 100 dyt | USUAL OCCUPATION (Give king most of working life, ever | ind of work done n if retired) | 10b. Kit | ND OF BUSINESS OR DUSTRY | прапи | 11 BIRTHPLACE (Stot | e or foreign country) | | 12 CITIZEN OF W COUNTRY? | HAT ISA |
| within 24 pencil in I xaminer's 'ile pages] | 13. | FATHER'S NAME Conis Doerfl | | 10000 | .0001103 (61 | n Door no | 14. MOTHER'S MAIDEN | NAME | | | DA |
| executed wending" in pending! in permit. File | 1S (Y | WAS DECEASED EVER IN U.S. s.no. or unknown) (If yes g | ARMED FORCES? | of service) | OCIAL SECURITY NO 11-28-8220 | 1 | nformant th Doerfle | in Sidu | hayer A | venue a. Mary | land |
| d be d "pe Chief Tramsit tramsit | | 18 CAUSE OF DEATH (ET PART 1 DEATH WAS | nter only one cau CAUSED BY MMEDIATE CAUSE DUE | (o) F'8 | | norp | hosis of l | iver with | 1 | INTERV | AL BETWEEN AND DEATH |
| s certificate should e, writing the ward farwarded ta the Ch used as a burial-tra | | Conditions, if any, which rise to immediate couse stating the underlying colors | gove) | (b) (TO | Cerebral | fat | embolism | | | | |
| 2 2 2 / | VIION | PART II OTHER SIGNIFICAN | NT CONDITIONS C | (r) Ontributing to | O DEATH BUT NOT REL | ATED TO T | HE TERM NAL D SEASE CO | OND TION GIVEN IN PA | RT 1(o) | 19. W/ PEI YES | AS AJTOPSY REORMED? |
| INER: This ee certificate, shauld be fa files. 3 shauld be u shauld be u | L CERTIFICATION | 200 EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTI CAUSE OF DEATH | | 20b DES | CRIBE HOW INJJRY O | CJRRED | Enter nature of injury in | Part I or Part II of it | em 18) | 1 | 3(|
| 3 = 12 = 12 | MEDICAL | 20c TIME OF INJURY Mor Hour o.m p.m. | 19 | While of work | | focto | E OF INJURY (Home, for ory, street, office bldg, etc | | r town) | (County) | (Stote) |
| DEPUTY MESTAL EXAM scessary, please execute the e funeral directar. Page 4 may be retained for your FUNERAL DIRECTOR: Page salth ar its designated age | | 21. I certify that death resulted fee | | | oins described ab | ave, be Suici | d an Autapsy 🔀 de 🔲, Homicid | Inspection \(\sum_{\text{order}} \) | Inquiry nined manne | | my op niar |
| r Mecry please al director retainer L DIREC | | ACTUAL SIGNATURE | elde | En f | Che las | zp | (N, D | DICAL EXAMINER | 1.1 | 22. | DATE SIGNED |
| TO DEPUTY MEDICAL necessary, please est the funeral director. S may be retained TO FUNERAL DIRECTOR Health ar its design | | EXAMINER'S RAME (Type) REL | DEIV | RI | KEAR | 191,1 | | July Colyn, or count | | 26// | 167 |
| TO I the S II Hec | L | BURIAL, CREMATION, REMOVAL (Specify) | Apr 2 | 6, 1967 | | | Crematory | | George | | (Stote) |
| VR A15ME (5) | 13 | FUNGRA DIRECTOR | extilla | Jacker, | 8434 GEONESS | ria f | Carlotte Address of the Control of t | D BY REGISTRAR | | LICALIAN | udge |

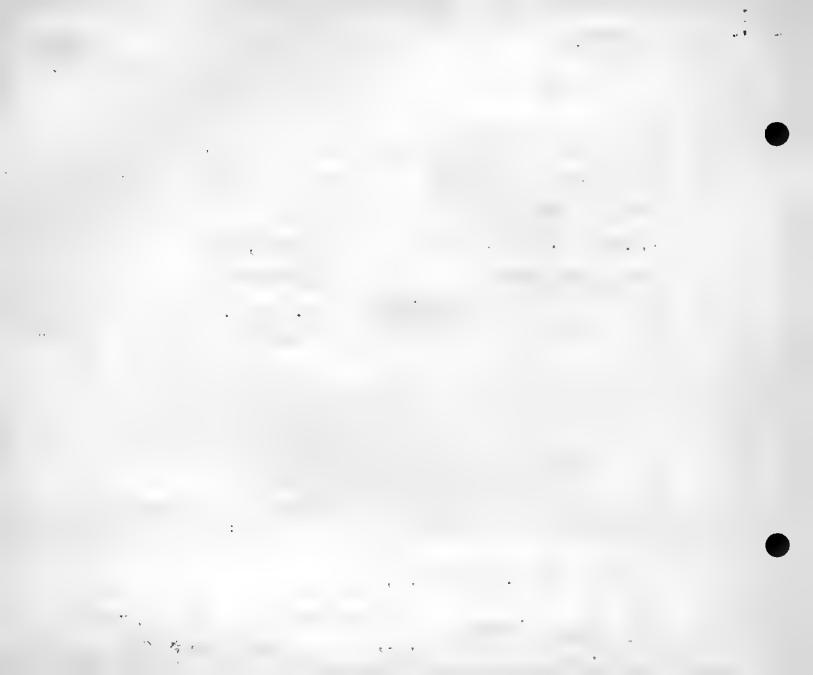


DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 05329 requires that the death tertificate be executed within 24 hours after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. COUNTY b. PHONTGOMER ONTGOMER MARYLAND c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLENGTH OF STAY IN 16 papers. Pag h/n 72 hours (SILVER SPRING AICOMA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e IS RES DENC ON A FARM: YES carbon NAME OF Middle DATE Doy Year DECEASED OF DEATH 196 (Type or pont) AGE (In veors MARRIED NEVER MARRIED lost birthdoy) Months Doys Hours WIDOWED 10o USUAL QCGUPAT ON (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & Stote, or foreign country) 12 CITIZEN OF WHAT during most of working life even if retired) attending physicion opermit. Then pleose INDUSTRY. COUNTRY? Jun home 13. FATHER'S NAMI 14. MOTHER'S MAIDEN NAME signed by the attending physi buriol-tronsit permit. Then pl buriol, cremation, or removal, 15 WAS DECEASED EVER IN U.S. ARMED FORCES? Address 5602 42nd Ave. 16 SOCIAL SECURITY NO (Yes, no or unknown) (If yes give wor or dotes of service) Ues 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE CAUSE (o) by the hospital or attending physician. DUE TO Conditions, if ony, which gove rise to immediate couse (a), DUE TO stating the underlying couse with the State Dept. of Health prior to tost WAS AUTOPSY PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) PERFORMED? NO M 20a. ACCIDENT WAS UNDERLYING [20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c. TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour om. Not While factory, street, office bldg, etc.) 21. I certify that (1) (this hospital) attended the deceased fram OC be retained and that death occurred at 740 M. from causes and on the date stated above. TO FUNERAL DIRECTOR: saw the deceased alive on A 220. SIGNATURE 22b. DATE SIGNED director, page 3 should be filed v M.D 22d ADDRESS Page 4 moy ! 22c PHYSICIAN S mD. Carroll AVE NAME (Type) 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) BURIAL, CREMATION 23b. DATE THEREO! (Stote) (County) REMOVAL (Specify) Pincoln Cemetery 25by ALGISTRAR'S SIGNATURE 8434 Georgia Avenue VR A15 (4) 25M 1/67 DATE Warner



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05330 CERTIFICATE OF DEATH The law requires that the deoth certificate be executed within 24 hours after death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission p (CUNTY o. STATE b. COUNTY MONTYOMERY MARYLAND b CITY OR TOWN (If outs de corporate limits, write RURAL and give nearest town) c LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA 22 DAYS FORREST HEIGHTS d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. LS RESIDENC ON A FARM? OTTAWA ST. I NO T NAVAL HOSPITAL YES 3. NAME OF Middle 4. DATE Lost Year DECEASED (Type or print) Albert Jahn Donehoo DEATH April 19 event, IF JNDER I YEAR IF JNDER 24 HRS S SEX 6 COLOR OR RACE 7. MARRIED B DATE OF BIRTH 9. AGE (In years **NEVER MARRIED** remove lost birthdoy) Months Dovs Hours CAUC and in ony MALE WIDOWED DIVORCED 31 DEC 02 10o, USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12 CITIZEN OF WHAT physician a nen please during most of working life even if retired)
U.S.NAVY Lt. Co Retired COUNTRY? ATTANTA GEORGA

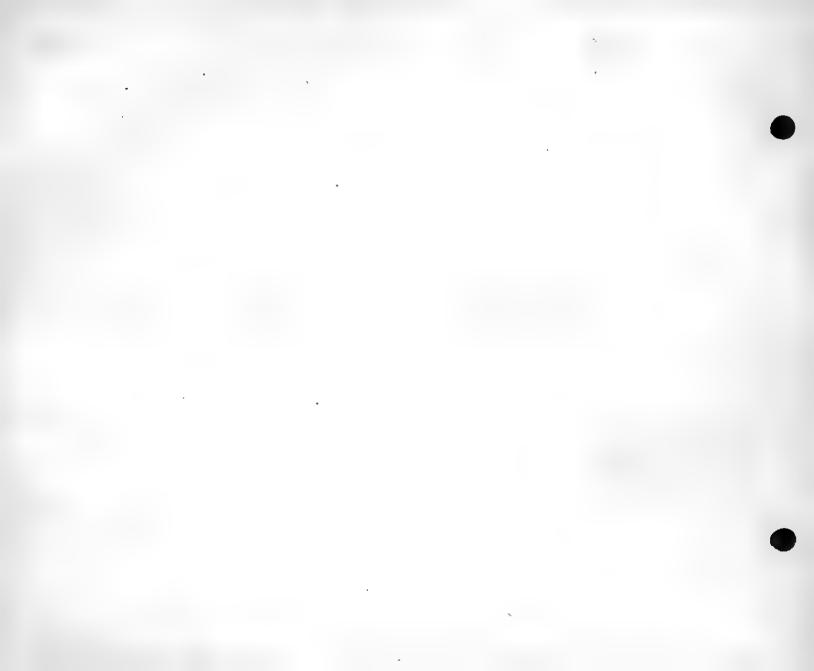
14. MOTHER'S MAIDEN NAME USA 13. FATHER'S NAME or removo JOHN ALBERT DONEHOO ALTCE UNKNOWN IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT Address #2 (Yes, no, or unknown) (If yes give wor or dates of service) 578-50-2909 Same as Item YES MRS. TRENE A. DONEHOO 1B. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY. INTERVAL BETWEEN PRIMARY CIRRHOSIS OF LIVER IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gove (b) nse to immediate couse (a), DUE TO stoting the underlying couse 19. WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) certificate has NO 20o ACCIDENT WAS UNDERLYING □ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH State Dept. of (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e, PLACE OF INJURY (Home, form, 20f. (City or town) 20c. TIME OF INJURY Month, Dov. Year 20d INJURY OCCURRED (County) (Stote) Hour om. foctory, street, office bldg., etc.) Not While of work ot work IT MARCH 101 to 7 APRIL . 167 , that (I) (we) last 21. I certify that (I) (this haspital) attended the deceased fram. be retained saw the deceased alive an 7 APRTI, 67 19 , and that death accurred at 5.10TM, from causes and an the date stated above. 220 SIGNATURE DIRECTOR M D 22d ADDRESS Poge 4 moy DAVID R. FOREMAN LT.MC.USN 23o BURIAL, CREMATION, 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) REMOVAL (Specify) Apr. 12-67 0 ARLINGTON NATIONAL ARLINGTON ADDRESS 250 REC'D BY REGISTRAR VR A15 (4) 25M 1/67 1661 GOOD HOPE ROAD, SE, WDC



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH TOR STATE 95331 MEALTH DEP I. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence be p COUNTY Poge 017 96 mei MARYLAND (If putside corporate limits c. LENGTH OF STAY IN 16 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d STREET ADDE farm Hospital Suhurban YES in Item 18. Give Pages Examiner's Office olang with NAME OF OFCFASED (Type or print) OF DEATH MARRIED K JELINDER 1 YEAR S. SEX R MARRIED 9 AGE IF LINDER 24 HR Months Doys Hours W DOWED DIVORCED any event within 72 hours after death. 10b, KIND OF BUSINESS OR 12 CITIZEN OF WHAT COUNTRY 17 INFORMANT IS. WAS DECEASED EVER NUS ARMED FORCES? JOCIA, SECURITY NO CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN PART I DEATH WAS CAUSED BY Jeekey Acute IMMEDIATE CAUSE (a) e, writing the word forwarded to the Ch Cardio Vascular Disease DUE TO Years. Conditions, if any, which gove nse to immediate couse (a), DUE TO stoling the underlying couse Inst 19 WAS AUTOPSY PERFORMED? removal, PART II. OTHER S GNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) NO A 20o EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port or Port II of tem 18) 3 should PRIMARY Or CONTRIBUTING CAUSE OF DEATH MEDICAL 20e PLACE OF INJURY (Home, form, 20f. (City or town) 20c TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED (County) (Stote) Hour o.m. foctory, street, office bldg., etc.) Not While FUNERAL DIRECTOR: Page of work of work Inspection X Inquiry X 21. I certify that I taak charge of the remains described above, held an Autopsy and in my apinian deoth resulted fram: Natural causes 🕱 Accident 🗔 Suicide 🗔 Homicide Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED prior SIGNATURE 12/DEPUTY MEDICAL EXAMINER 🔀 NAME Type, Och. Address (Street city, town, or county) 230 BUR A REMATION. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City of Town) REMOVAL (Specify) rato i National FUNERAL DIRECTOR 256 RECISTRAR S SIGNATURE VR A15ME (5) 6M 1/67

Corder Processi Til 1 11

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE 053**30** PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, finistitution. Residence before admission) o COUNTY MARYLAND delay b CITY OR TOWN (If outside opporate limits, CLENGTH OF STAY IN 16 ond green neorest town outside corporate limits, write RURAL gud write RURAL and give negrest town ofter d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS IS RESIDENCI hours Office olong with form ON A FARM? in Item 18. Give Poges ote YES 🔲 NO X after death 3 NAME OF First Middle Day Year DECEASED The The OF DEATH WIVEY (Type or print) 19 SEX NEVER MARRED B DATE OF BIRTH 9. AGE (In years 6 COLOR OR RACE 7 MARRIED IF UNDER YEAR IF UNDER 24 HRS lost birthday) Months Doys Hours hours DEWOODEN DIVORCED and 2 10o, USLA, OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR (State or foreign country 12 CITIZEN OF WHAT during most of working I to, even it retired) COUNTRY? INDUSTRY ony pending" in pencil in of Medical Examiner's 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAM ond 16 SOCIAL SECURITY NO be executed ar removal (Yes, no, or unknown) (If yes give war or dates of service 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN enjo Periostelium. Mass We. stamponade **buriol-tronsit** PART I DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o). certificate, should writing the word burial, cremotion, DUE TO to the Rupture. Thorseic horts , Spontaneous -Conditions, if ony, which gove rise to immediate couse (a). DUE TO storing the underlying couse 10 Cystic Medic Necrosis of Aorth IdioPathic last. used PART II. OTHER SIGNIFICANT COND TIONS CONTRIBUTING TO DEATH BLT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY PERFORMED? YES X NO Be D 200 EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port or Port II of item 18.) ogent, prior 3 should PRIMARY OF CONTRIBUTING CAL EXAMINER: CAUSE OF DEATH 20d INLURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20c TIME OF NJJRY Month, Doy, Year 20f (City or town) (County) (State) Hour o.m. foctory, street, office bldg., etc.) moy be retoined for your FUNERAL DIRECTOR: Page Not While ot work ot work 21. I certify that I took charge of the remains described above, held an Autopsy 17. Inspection ... Inquiry ond in my opinion Undetermined manner Naturol causes 💢 Suicide . death resulted from. Accident Homicide | CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE TO DEPUTY 5 moy be ro FUNERAL Health or i DEPUTY MEDICAL EXAMINER Address Street; city town, or county) BLIR.A. CREMATION DATE THEREOF OR CREMATOR 23d. LOCATION (City or Town (Stote) Com, Cemelen VR A15ME (5) Microson



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 05333 requires that the death certificate be executed within 24 hours after death 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) a. COUNTY b COUNTY Montgomery Maryland Montgomery I, and in any event, within 72 hours after MARYLAND b CITY OR TOWN (If autside carparate lim is, write RURAL and give nearest tawn) CLENGTH OF STAY IN 16 c CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) Bethesda Bethesda d. NAME OF HOSPITAL OR INSTITUTION (if nat in haspital, give street address) d. STREET ADDRESS IS RESIDENC ON A FARM? completely filled 4743 Bradley Blvd. Bradley Blvd. YES NO D 3 NAME OF Middle Last 4. DATE Manth First Day Year remave carba DECEASED ADRIAN OF DEATH April DURHAM 19 67 Sr. (Type or pont) 5 SEX 6. COLOR OR RACE NEVER MARRIED 8 DATE OF BIRTH AGE (In years IF UNDER 1 YEAR | IF UNDER 24 HRS. 7 MARRIED Jost birthday) Rours White Male July 6. **G3WODIW** DIVORCED 10a. USJAL OCCUPAT ON (Give kind at work done during mast at warking life, even if retired) 12 CITIZEN OF WHAT 10b. KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) INDUSTRY COUNTRY? S. Fairfax County. Air Engineer Retired 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME burial, crematian, ar remava Molly Scott Frank Durham 15. WAS DECEASED EVER IN J.S ARMED FORCES? (Yes, na, at unknown) (If yes give war at dates of service) 16 SOCIAL SECURITY NO 17 INFORMANT Wife burial-transit permit. Same as Item 2. 579-60-7204 Margaret H. Durham Yes I-Navv 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY INTERVAL BETWEEN ONSET AND DEATH ercpra IMMEDIATE CAUSE (a) DUE TO Conditions, of any, which gave (b) rise to immediate cause (a), DUE TO stating the underlying cause as the WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(g) far Use YES -NO O FUNERAL DIRECTOR: After this certificate director, page 3 should be detached far us 205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame, form, (City or town) (County) (State) 20c. TIME OF INJURY Manth, Day, Year factory, street, affice bldg., etc.) Not While at wark at wark 21. I certify that (i) (this hospital) attended the deceased from 1967, and that death accurred at 25 M, from causes and an the date stated above. . 19 64, to April 13, 1962, that (1) (402) last saw the deceased alive an. 22a SIGNATURE 22b. DATE SIGNED ATTENDING M.D. PHYS directar, page should be filed 3000 Dent Place 22c. PHYSICIAN'S STEPHEN HULBURT NAME (Type) Washington. 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 23g BURIAL, CREMATION, 23b. DATE THEREOF (County) REMOVAL (Specify) Falls Church, Virginia 4-17-67 Natl. Mem. Park Cem. PUMPHREY, Bethesda, Maryland 25h REGISTRAR'S SIGNATURE VR A15 (4) 20 M 1/66



| | DIVISION OF STATISTI | MARYLAND STATE DE CAL RESEARCH AND RECORD | | HEALTH ! Street, Baltimor | E 1. MARYLAND |
|---------------|---|--|---|--|---|
| | 05334 | | E OF DEATH | · | 05339 |
| | . PLACE OF DEATH | | 2. USUAL RESIDENCE | (Where deceased lived, If Insti | tution: Residence before admission |
| 1 | HONTROMERY | / MARYLAND | a. STATE | b. CDUNT | HONTOOMERY |
| П | b. CITY OR TOWN (If outside corpore write RURAL and give nearest toy | te limits, c. LENGTH OF STAY IN 1b | c. CITY DR TDWN (If o | utside corporate limits, writ | e RURAL and give nearest town |
| | SILVER SPRING | DN (if not in hospital, give street address) | - 1 V C / V / / / | Ε | , , |
| | 1/./ Pare of Hospital of Institution | on (it not in nospital, give street address) | d. STREET AOORESS | - D. | 6. IS RESIDENCE DN A FARM? |
| 3 | NAME OF F | ISPITAL Middle | Last | The same of the sa | YES ND |
| | DECEASED (Type or print) TANICE | R. MILLIE | ISCIV | 4. DATE Month OF DEATH | Day Year /2 196 7 |
| 5 | . SEX 6. CDLDR OR RACE | 7. MARRIED NEVER MARRIED | 8. DATE OF BIRTH | 9. AGE (In years I | FUNDER 1 YEAR IF UNDER 24 HRS |
| | FC | WIDDWEO DIVORCEO | 1/2964 | iast birthday) N | Months Oays Hours Min. |
| 1 | Da. USUAL DCC UPATION (Give kind of work uring most of working life, even if retire | done 10b. KINO DF BUSINESS DR | 11. BIRTHPLACE (Cou | nty & State, or fereign country) | 12. CITIZEN DF WHAT COUNTRY? |
| _ | MINUE 3. FATHER'S NAME | | HARYLAN | ud | U.S.A. |
| ľ | D.1 1 D | . / | 14. MOTHER'S MAIDE | 0 / | |
| _ | 5. WAS DECEASED EVER IN U.S. ARMED FO | VSCN Drces? 16. SDCIAL SECURITY NO. 17. | INFORMANT | Gaunt | |
| (| Yes, no, or unkown) (If yes give war or dates o | of service) | BALL BALLETING | Aug 603 | |
| = | 18. CAUSE OF DEATH LEnter only on | ne cause per line for (a), (b), and (c),] | | | INTERVAL BETWEEN DNSET AND DEATH |
| | PART I, OEATH WAS CAUSED BY IMMEDIATE CAUSE | | alienane | | DNSET AND DEATH |
| | DUE | | ð |) | 4. |
| | Conditions, If any, which gave rise to Immediate | (b) Wilmy (7 | ing | | 2 yrs. |
| | cause (a), stating the DUE | | | | |
| NO | underlying cause last. PART II. OTHER SIGNIFICANT CONDITIES | (c) DNS CONTRIBUTING TO DEATH BUT NOT REL | ATED TO THE TERMINAL DIS | SEASE CONDITION GIVEN IN P | ART1(a) 19. WAS AUTDPSY PERFORMEO? |
| CERTIFICATION | | | | | PERFORMEO? |
| PTIE | 200. ACCIOENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEA (IF EITHER, NOTIFY MEDICAL EXAMI | TH 20b. DESCRIBE HOW INJURY DCC | URRED. (Enter nature of I | njury in Part I or Part II of | |
| | | | | | |
| MEDICAL | 20c. TIME DF INJURY Month, Oay, Hour a.m. | · · · · · · · · · · · · · · · · · · · | ACE DF INJURY (Home, farm ory, street, office bldg., etc | n, 20f. (City or town) | (County) (State) |
| ME | | at work at work | 11 10 | | |
| | 21. I certify that (I) (this host saw the deceased alive on | pital) attended the deceased from | 4 - 0 - 19 | | , 19 كي لم that (i) (we) ias nd on the date stated above |
| | 22a. SIGNATURE | 1912, and tha | | ALEM, Ironi the causes a | 22b. DATE SIGNEO |
| l | 1 1 XX CL | nea M. | D. PHYS. DI | RECTOR PHYS. | 4-13-67 |
| | NAME (Type) ALLAN | B. COLEMAN, MID | 22d. AODRESS | METALOR, NW. | Men De Jan |
| 3 | | | | | |
| 2 | BURIAL (Specify) BURIAL (Specify) BURIAL 4/15 | | VEN | SILVER SPR | ING, MONTG., MD. |
| 17 | 4. FUNERAL DIRECTOR | AOORESS) | | D BY REGISTRAR 25b. REG | SISTRAR'S SIGNATURE |
| t | Dens K. In | onden tecker | LLG TOMPR | 13 1967 gely | arles Judges |
| Ť | | | | V | U |

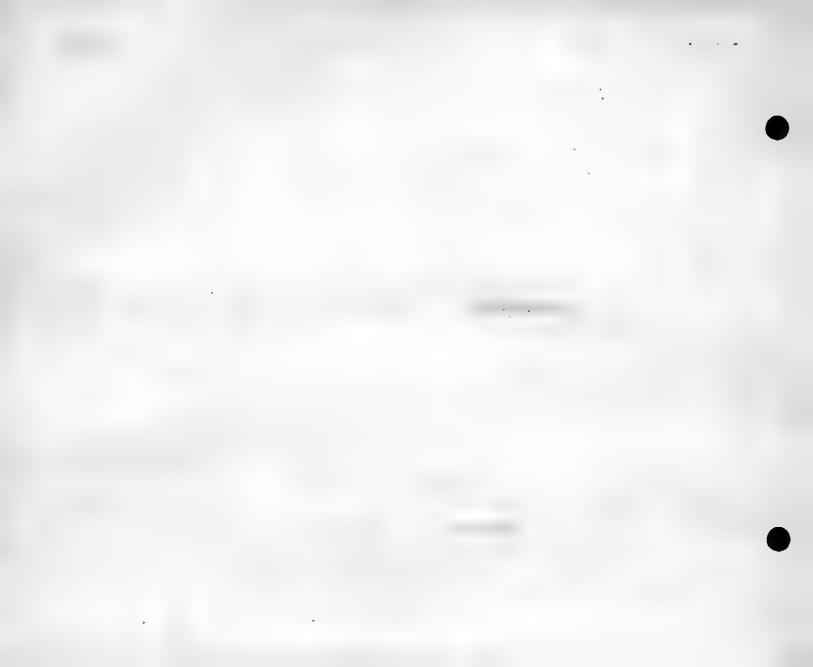


--+ 4

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 05336 death I. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) o COUNTY b COUNTY o. STATE oon papers. Poges I within 72 hours after MONTGOMERY MARYLAND The low requires that the death certificate be executed within 24 hours after b CITY OR TOWN (if outside corporate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside carparate limits, write RURA) and give nearest town) 6 DAYS HYATTSVILLE RETHESDA d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) B IS RESIDENCE ON A FARM? .⊆ d STREET ADDRESS filled 3900 CALVERTON DRIVE NAVAL HOSPITAL NO TX 3. NAME OF DATE Middle Month Year remove carbon Lost DECEASED (Type or pont) OF DEATH APRIL 19 67 EDWIN SHELL EARNHARDT and in any event, IF UNDER 1 YEAR IF UNDER 24 HRS 9. AGE In years 6 COLOR OR RACE DATE OF BIRTH 7. MARRIED NEVER MARRIED last birthday) Months Hours WIDOWED DIVORCED JUN. 10.1895 CAUC MALE puo 10b. KIND OF BUSINESS OR 12 CIT ZEN OF WHAT COUNTRY? 100-USUAL OCCUPATION (Greekind of work done during most of work har life; even if retired) 11 BIRTHPLACE (County & State, or foreign country) U. Busik Government LENOTR N. CAROLINA
14. MOTHER'S MAIDEN NAME USA ŬS NAVY 13 FATHER S NAME Earnhardt BLANCHE UNKNOWN 17. INFORMANT IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 3900 CALVERTON DRIVE (Yes, no, or unknown) (If yes give wor or dotes of service) GLADYS R. EARNHARDY HYATTSVILLE, MARYLANI YES WW I & 2 INTERVAL BETWEEN 18 CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY: signed by the burial-tronsit ONSET AND DEATH IMMEDIATE CAUSE (a) Severe Coronary Atherosclerotic Cardiovascular O HOSPITAL OR ATTENDING PHYSICIAN: The low requires the Page 4 may be retained by the hospital or ottending physicion. Disease DUE TO Conditions, if any, which gave (b) rise to immediate couse (a), DUE TO stating the underlying couse s should be detached for use as the with the State Dept. af Health prior to WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDIT ON GIVEN IN PART I(a) YES K NO this certificate 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of item 18) 20o. ACC DENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 20a INTERY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) foctory, street, office bldg., etc.) Hour o.m. 2]. I certify that (this haspital) attended the deceased from APR Q , 1967 to APR saw the deceased alive an APR714 19 67, and that death occurred of 2257th, fram causes and an the date stated above O FUNERAL DIRECTOR: 22g SIGNATURE 22b. DATE SIGNED MED. DIRECTOR STAFF PHYS 16 April 1967 M.D. 22d, ADDRESS 22c PHYSICIAN'S Naval Hospital, Bethesda, Maryland W. H. SPAUR, LCDR MC USN NAME (Type) 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 23b. DATE THEREOF (State) 23o. BURIAL, CREMATION (County) REMOVAL (Specify) VA. ARLINGTON ARLINGTON NATIONAL 250 REC'D BY REGISTRAR 24. FUNERAL DIRECTOR **ADDRESS** 2Sb _REGISTRAR S_SIGNATURE VR A15 (4) 25M 1/67 FRANCIS GASCH'S SONS, HYATTSVILLE, MD.



| | _ 1 / 1 | Le | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 |
|------|--|---------------|--|
| 12 | FOR STATE | | 95337 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05335 |
| | HEALTH DEPT | 1. | PLACE OF DEATH 2. USUAL RESIDENCE (Wingre deceased lived, if institution Residence before admission) 4. COUNTY b. COUNTY |
| vf s | v is to tof | | Monigomery Maryland Maryland |
| 7 | y delay is y and 3 to PM3. Poge ortment of | | C (ITY OR TOWN (If outside corporate Whits, C. LENGTH OF STAY IN 1b C (ITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) |
| | P. P. C. | | akona Vark J.S.T. Stat Vilavant |
| • | f ar | 2 | 1. NAME OF HOSP TAL OR INSTITUTION (if not in hospito, give street oddress) of STREET ADDRESS ON A FARM? 1. NAME OF HOSP TAL OR INSTITUTION (if not in hospito, give street oddress) ON A FARM? TO STREET ADDRESS ON A FARM? YES \(\sum NO \(\sum \) |
| | after death. If any delay is 8. Give Pages 1, 2, and 3 to along with form. PM3. Page with the state deportment of | | NAME OF First Thomas Emelio 14. DATE Month Doy Year DECEASED OF DEATH 4 27 1967 |
| | hours after death I Item 18. Give Pages Office along With for Indead 2 with the State | S | SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED B DATE OF BIRTH 9. AGE (In years light birthday) Months Doys Hours Min. |
| | hin 24 hours act in Item 18 niner's Office of pages I amd 2 v | 10o dur | US JAL OCCUPATION (Give kind of work done INDUSTRY INDUSTRY INDUSTRY INDUSTRY INDUSTRY) 12. CITIZEN OF WHAT COUNTRY? |
| | I within 24 hours after death mental in Item 18. Give Page Emminer's Office along with File males I and 2 with the State I hours ofter death. | | FAGHER SMAME 14 MOTHER'S MAIDEN NAME Salvatore D. Emilio Mary Hessler |
| | xecuted w iding' in Medical Emp permit. File | | WAS DECEASED EVER N J.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17. INFORMANT Address W 14 5 h DC |
| | ecut ing ing ing ing ing ing | | yes 15/-28 6486 Mary & Comelin - 3966-PA. AVE SE |
| | should be executed within the mord "planding" in mental to the Chief Medical Ememine bund-transit permit. File more on a congression only event within 72 hours of | | TIB CAUSE OF DEATH (Enter only one couse per line for (o), (b) and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) Multiple extreme fractures of the left ONSET AND DEATH |
| | ord Ch | | C 4 > TH DUE TO |
| | shou the trial | | Conditions, if ony, which gove (b) femur, left ilium, left arm and ribs |
| | ertificate should writing the mord recorded to the Convorded to the Cosed os a burial-truck, and in any every. | | stoting the underlying couse ost (c) with exsanguination |
| | 0 5 8 4 / | NOIL | PART I OTHER SIGN FICANT CONDITIONS CONTR BLTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDITION GIVEN IN PART I(o) 19. WAS AUTOPSY PERFORMED? YES \ NO |
| | MEDICAL EXAMINER: This cert leme execute the certificate, writalisetor. Page 4 should be farwo toined for your files. DIRECTOR: Page 3 should be used to burial, cremotion, or removol, | CERT FICATION | 200. EXTERNAL CAUSE WAS PRIMARY Mor CONTRIBUTING CAUSE OF DEATH. 20b DESCRIBE HOW IN.URY OCCURRED (Enter noture of injury in Port I of Port II of tem IB) Deceased found dead beside wrecked motorcycle on Riggs Road |
| | EXAMINER: Lute the certificate of should your files. Poge 3 shou cremotion, o | EFFICAL | 20c YIME OF IN IISRY Month, Doy, Year 20d INSURY OCCURRED 20e PLACE OF INSURY (Home, form 20th (City or town) (County) (State) |
| | L EXAM secure the Page 4 for your Mr. Poge | | 2:50 pm 4-27 1967 While Not While Street Street Hyattsville PrGeo Md. |
| | A EX Kecuto Page for yi OR: Po | | 21. I certify that I took charge of the remains described glave, held an Autopsy 💢 , Inspection 🤘 , Inquiry 💢 , and in my opinio |
| | ECTOR burial, | | deoth resulted from Accident A. Suicide ., Homicide ., Undetermined monner |
| (| | | ACTUAL SIGNATURE SIGNATURE ACTUAL SIGNATURE ACTUAL SIGNATURE ACTUAL SIGNAT |
| | E SE SE | | EXAMINER'S RELIGIOUS PARTY REPORT OF THE PROPERTY OF THE TOTAL PARTY OF THE PROPERTY OF THE PR |
| | TO DEPUTY necessary, that funera 5 moy be TO FUNERA! Health prin | 23 | BURIAL, CREMATION. 236 DATE THEREOF 23C NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (State) |
| | F . | - 0 | REMOVAL (Specify) May 2-1967 Alexandria Nat'l. Cenetery Alexandria. Virginia ADDRESS ADDR |
| | VR A15ME (5) 6M 1/67 | S | ADDRESS ADDRESS ADDRESS ADDRESS ADDRESS ADDRESS ADDRESS ADDRESS DATE MAY 1 1967 ADDRESS DATE MAY 1 1967 |
| | | _ | |



| - 1 | | | MARYLAND STATE DEPARTMENT OF HEALTH | BARDWI AND |
|--|---|---------------|--|-------------------------------------|
| | Z = | | DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, CERTIFICATE OF DEATH | MAKTLAND 22C |
| death. funeral | and 2 death, | 1. | PLACE DF DEATH a. COUNTY b. COUNTY b. COUNTY | Residence before admission) |
| hours after | hours after | | Monte Maryland Md. Monte | gome ry |
| s af | ନ ଅନୁକ ଅନ୍ୟ | | b. CITY OR TOWN (if outside exporate limits, write RUR/ write RURAL and give newest town) c. LENCTH OF STAY IN 1b | L and give nearest town) |
| our | hou | C | DILVER SPLING / Months Olney | 15.1 |
| 24 h | e Kalen | | d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS | e. IS RESIDENCE ON A FARM? |
| FA 30 | | 44 | Intromety Conv. & Nuesing Hone | YES NB |
| executed within | event, within | 3. | NAME OF DECEASED A First Middle Last 4. DATE Month | Day Year |
| W P | E a ca | | (Type or print) Charlette E. G. PARQUALT DEATH X- | 29 196/ |
| executed a and cor | 8 8 | 5, | SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. ACE (In years IFUNDE last birthday) Months | RIYEAR IF UNDER 24 HRS. |
| and | any | 10 | emale White WIDOWED DIVORCED 11-22-1814 92 yrs. | |
| be e ician | arie (| 10a dur | USUAL OCCUPATION (Give kind of workdone 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, of foreign country) 12. INDUSTRY | CITIZEN OF WHAT COUNTRY? |
| e b | and in | | Housewite Home | 115H |
| icat Phy | . Then ples removal, ar | 13. | FATHER'S NAME 14. MOTHER'S MAIDEN NAME | 1 |
| ing | ar i | | homas Grillith Elizabeth Singleton | |
| 20 == | or ii. | [5. | WAS DECEASED EVER IN U.S. ARVED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address 1, no, or, unknown) (If yes give ways) dates of service) | |
| The law requires that the death certificate or attending physician, sate has been signed by the atterming physical | ELTHOUSE, C | ,,,, | NO 215-48-38/4 Mrs. Catherine Willcox Gait | hersburg, Md. |
| the d | as the burial-transit perm prior to burial, cremation, | | 18. CAUSE DF BEATH [Enter only one cause per line for (a), (b), and (c).] | INTERVAL BETWEEN ONSET AND DEATH |
| ulres that the g physician. In signed by th | ans ren | | PART I. DEATH WAS CAUSED BY: Interprine aslama, accety | 12 hus |
| tha sicia ned | 9-t- | | 7 of Jr. DUE TO | |
| res phy sig | uri. | Ш | conditions, If any, which) Billio Salerobe cardiovosculo, illnesse | 2044 |
| requir ding p | 55 12 | | gave rise to immediate cause (a), stating the DUE TO | |
| law requires that tattending physician. Has been signed b | s th | | underlying cause last. (c) | |
| atte ha | ched for use as t pt. of Health prior \$\int\$\$ | CERTIFICATION | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION CIVEN IN PART 1(2) | 19. WAS AUTOPSY PERFORMED? |
| or or cate | eate 3 | [S | | YES NO |
| SICIAN: hospital is certific | 유표 | III | 20s. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 11 of Item 1 OR CONTRIBUTING CAUSE OF DEATH | 8.) |
| Se los | of. o | 9 | (IF EITHER, NOTIFY MEDICAL EXAMINER) | |
| PHYSICIAN: the hospita this certifi | Se Se | MEDICAL | Parties and the second | ounty) (State) |
| 3- | be de State | (ED | Hour a.m. p.m, 19 While Not While factory, street, office bldg., etc.) at work at work | |
| | 0 0 | ~ | 21. I certify that (I) (this hospital) attended the deceased from 11-7 1968 to 4-29 199 | Z that (I) (we) last |
| ATTENDI retained CTOR: A | 3 should with the | Н | saw the deceased alive on 4-28 1967, and that death occurred at P. M., from the causes and on | / ' |
| re re | witi witi | | 22a. SICNATURE 22b. | DATE SICNED |
| ol be | ed | П | M.D. ATTENDING DIRECTOR DIRECT | '1/67 |
| TAL may | e fi | | 22c. PHYSICIAN'S 22d. ADDRESS | - M3 |
| 드 4 급 | director, page should be filed | | NAME (Type) A.D. Bonifant, M.D. Medical Center, Sandy Sprin | g, maryland |
| Page Fun | dire | 23a | BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or CREMATORY) | county) (State) |
| 5_5 | 1 | | Burial 5 - 2- 67 St. Johns Olney, Md. | |
| | inti | 24. | FUNERAL DIRECTOR ADDRESS 25a. REC'D BY RECISIRAR 25b. REGISIRA | R'S SICNATURE |
| VR A15 | | | Francis H. Barber Laytonsville, Md. DAMAY 2 1967 Ichan | les judge |



DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 05337 05333 The law requires that the death certificate be executed within 24 haurs after death. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if 'nstitution, Residence before admission) o. COUNTY h. COUNTY Except Maryland Montgomery MARYLAND Carroll Pages b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) filled in by the papers. Page thin 72 haurs a write FURAL and give nearest town) Sykesville Olney d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? filled YES NO TS Montgomery General Hospital NAME OF Middle 4 DATE carban × Month Year completely DECEASED 19 67 16 (Type or print) BABY BOY DEATH 8 DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF JNDER 24 HRS 6. COLOR OR RACE 7. MARRIED NEVER MARRIED lost birthdoy) Months Doys Haurs Yno m WIDOWED DIVORCED lı=16=67 White Male and 10o USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12 CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired) COUNTRY? physician (en please please INDUSTRY and U.S.A. none Montgomery, Md. none 14. MOTHER'S MAIDEN NAME 13. FATHER 5 NAME cremation, ar removal, Mary Fincham Perry Hankins attending p 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) (If yes give wor or dates of service) Hospital Records Olney. Md. none INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c), signed by the burial-transit burial, cremati ONSET AND DEATH PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) **10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires the Page 4 may be retained by the haspital ar attending physician. 776X DUF TO Conditions, if ony, which gove (b) rise to immediate cause (a). DUE TO stoting the underlying couse be detached for use as the State Dept. of Health prior ta 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) NO this certificate OR ATTENDING PHYSICIAN: 200 ACCIDENT WAS UNDERLYING 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Port 11 of item 18) OR CONTRIBUTING CAUSE OF DEATH None (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20d INTURY OCCURRED 20e. PLACE OF INJURY (Home, farm, (City or town) (County) (Stote) 20c. TIME OF NIJRY Month, Doy, Yeor factory, street, affice bldg., etc.) Not While Hour to.m. While at work ot work FUNERAL DIRECTOR: After (1) to_ 21. I certify that (I) (this hospital) attended the deceased from Amy 19 and that death occurred at 1005 AM, from causes and on the date stated above saw the deceased alive an 220 SIGNATURE 22b. DATE SIGNED DIRECTOR M.D. PHYS director, page should be filed 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Sandy Spring Med. Center. SAndy hester 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 230 BURIAL CREMATION DATE THEREOF (County) (Stote) REMOVAL (Specify) 0 Иd 25b REGISTRAR'S SIGNATURE 250. REC'D BY REGISTRAR 24 FUNERAL DIRECTOR



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05340 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STA PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY **b** COUNTY o. STATE any delay is 2, and 3 to P.M.3. Page State Department of ont clomeis MARYLAND (If autside carpbrote limits, C LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) wate RURAL and give negrest town) Penns Grove Greet d NAME OF HOSPITAL OR INSTITUTION (18 not in hospital, give street address) d. STREET ADDRESS IS RESIDENCE forwarded to the Chief Medical Examiner's Office along with farm N. Broad NO 🔽 in Item 18. Give Pages havrs after death. NAME OF Middle 4 DATE Lost Month Doy Year DECEASED 26 250 tin/ayson (Type or print) DEATH 1967 IF UNDER 1 YEAR S SEX DATE OF BIRTH 9 AGE (In years IF UNDER 24 HRS 6 COLOR OR RACE 7 MARRIED NEVER MARRIED lost birthday) Manths 8, 1940 26 WIDOWED D VORCED l and 2 w thin 72 hours after deat 10a USLA, OCCUPAT ON (Give kind of work done during most git working bayeven if retired) 10b. KIND OF BLSINESS OR 11. BIRTHPLACE (State or foreign country) 12 CIT ZEN DE WHAT COUNTRY ?S INDI.STRY CAMBRIDGE, MASS. This certificate should be executed within 24 permit. File pages 13 EATHER'S NAME 14 MOTHER'S MAIDEN NAME pencil DONALD J. FINLAYSON (DEC'D) ELEANOR PETERSON 16 SOCIAL SECURITY NO. 17 INFORMANT 15 WAS DECEASED EVER IN U.S. ARMED FORCES? Address (Yesungs or unknown) (If yes give war or dates of service) 068 32 5070 pending" NAVY RECORDS USNH BETHESDA, MARYLAND 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) INTERVAL BETWEEN burial-transit in any event PART I DEATH WAS CAUSED BY blast of Head Self inflicted S ONSET AND DEATH Shot Gun IMMEDIATE CAUSE (o) writing the ward 476X DUE TO Conditions, if ony, which gove (b) rise to immediate couse (a), DUE TO stating the underlying cause and SD be used WAS AUTOPS)
PERFORMED? PART OTHER SIGN FIGANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) remayal, CERTIFICATION NO 200 EXTERNAL CAUSE WAS PRIMARY St or CONTRIBUTING ☐ CAUSE OF DEATH 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of Item 18) 3 shauld shauld L Ь pulled tragger bloom MEDICAL EXAMINER: files crematian, 20d INJURY OCCURRED 20f (County) 20c TIME OF INJURY Month Doy, Year factory, street, affice bldg etc.) Not While FUNERAL DIRECTOR: Page Great 751/5 Minr. Mel at work 2). I certify that I taak charge of the remains described above, held an Autopsy Inspection X, Inquiry X, and in my opinion Natural causes Suicide 54 death resulted fram: Accident Homicide Undetermined monner funeral director. may be retained CHIEF MEDICAL EXAMINER 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE DEPUTY MED CAL EXAMINER DEP **EXAMINER'S** Hegith Address (Street, city, town, or county) NAME (Type) BURIAL, CREMATION, DATE THEREOF NAME OF CEMETERY OR CREMATORY 0 ADDRESS 2So REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE A15ME (5) DATA



MARYLAND STATE DEPARTMENT OF HEALTH OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND and 2 death. 1. PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. COUNTY a. STATE b. COUNTY TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and confolded in by the f director, page 3 should be detached for use as the burial-transit permit. Then please removestation papers. Pages 1 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give mearest town) LENGTH OF STAY IN 1b TOWN (If outside corporate limits, write RURAL and give nearest town) C. CITY OR e. IS RESIDENCE give street address OR INSTITUTION (if not in hospital d. STREET ON A FARM? NO K YES within NAME OF Middle DATE DECEASED (Type or print) DEATH 196 executed IF UNDER 1 YEAR IF UNDER 24 HRS 6. COLOBFOR RACE DATE OF BIRTH AGE (In ears 77. MARRIED NEVER MARRIED last birthday) Months WIDOWED DIYORCED #0a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR (County & State, on foreign country) 12. CITIZEN OF WHAT law requires that the death certificate be INDUSTR) 13. TATHER'S NAME 14. MOTHER'S MAIDEN 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SDCIAL SECURITY NO. **INFORMAN** 17. (Yes, no, or unkown) ((If yes give war or dates of service) CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Run or attending physician. IMMEDIATE CAUSE **DUE TO** Conditions, if eny, which gave rise to immediate DUE TO cause (a), stating underlying cause last. (c) CERTIFICATION 19. WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMED? No 📉 YES the hospital 202. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, (County) (State) 20c. TIME OF INJURY Month, Day, Year 20f. (City or town) factory, street, office bidg., etc.) Hour a.m. While Not While OR ATTENDING be retained by at work p.m. at work 21. I certify that (I) (this hospital) attended the deceased from and that death occurred at saw the deceased alive on M, from the causes and on the date stated above. DATE SIGNED 22b. 22a. SIGNATURE STAFF PHYS. ATTENDING PHYS. MED DIRECTOR M.D. Page 4 may PHYSICYAN'S NAME (Type) 22d. ADDRESS 220. (State) BURIAL, CREMATION, 23b. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) REMOVAL (Specify) urear 25b. REGISTRAR'S SIGNATURE FUNERAL DIRECTOR REC'D BY REGISTRAR VR A15 (4) 15M 4-64



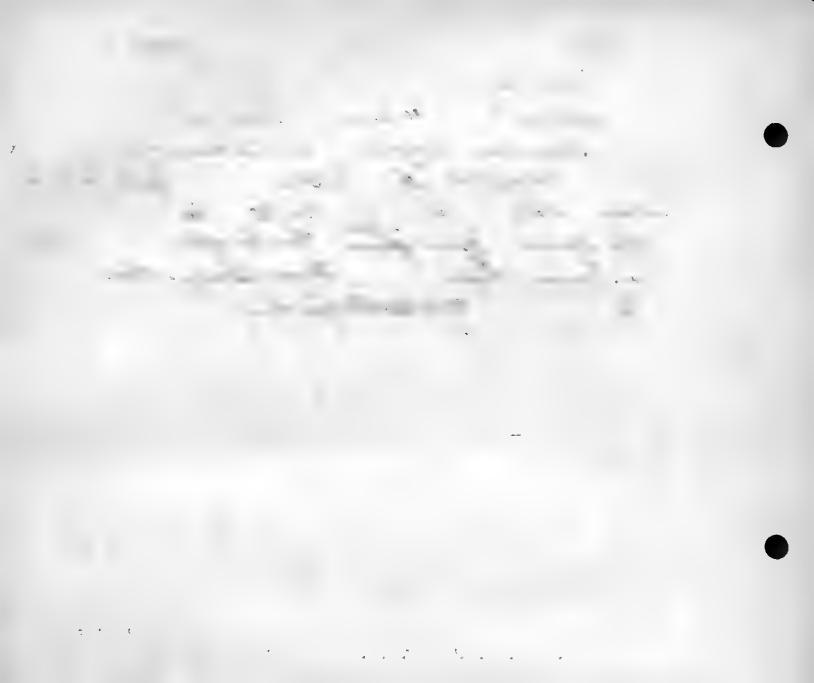
| 1 | MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH-AND RECORDS, 201 W. PRESTON STREET, BALTIMORE 1, MA | RYI AND |
|---|--|---|
| 点 液 の点 | 05342 Items 8 & 9 Film CERTIFICATE OF DEATH 053 | (40) |
| er death | 1. PLACE OF DEATH a. COUNTY ONTERY MARYLAND 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence of the county | idence before admission |
| 24 hours after filled in by the apers. Pages in 72 hours after | b. CITY DR TOWN (if outside corporate limits, write RURAL er write RURAL and give nearest town) c. CITY DR TOWN (if outside corporate limits, write RURAL er | nd give nearest town) |
| houn I in S. F | d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street eddress) d. STREET ADDRESS | e. IS RESIDENCE |
| | Westwood KetiREMENT HOME | DN A FARM? YES NO |
| d within upletely carbon ent with | | Day Year 1967 |
| be executed within 24 hours sician and completely filled in by lease remove carbon papers. Pagand in any event, within 72 hours | WIDOWED N DIVORCED 90 Vrs. | YEAR IF UNDER 24 HRS ays Hours Min. |
| sician sician and in | during most of working life, even if retired) INDUSTRY COU | IZEN OF WHAT NTRY? |
| cate b physici n pleas val, and | House wife - Wisconsin | USA |
| ertific | MICHEL RESCH AMELIA FRANK | |
| death certifics le attending pb permit. Then ion, or remova | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SDCIAL SECURITY ND. 17. INFORMANT Address WELL (Yes, no, or unknown) (If yes give war or dates of service) NOME ELEANOR FLYNN, 50, WINDEME! | ESLEY MASS RE ROAD. |
| he y th sit mat | 18. CAUSE DF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LINE CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).] | INTERVAL BETWEEN ONSET AND DEATH |
| The law requires that to or attending physician, rate has been signed bruse as the burial-tran ealth prior to burial, cre | Conditions, If any, which (b) arterincluste. | Severel you |
| aw requir tending p has been as the b prior to b | gave rise to immediate cause (a), stating the underlying cause last. | / |
| 4: The law cal or atten fiftcate has for use as Health price | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) | 19. WAS AUTDPSY PERFORMED? YES NO |
| 電車 温や田 | 20a. ACCIDENT WAS UNDERLYING 2Db. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of Item 18.) DR CONTRIBUTING CAUSE OF DEATH 2Db. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of Item 18.) IV. A. |) tend |
| DING PHYSICIA d by the hospi After this cerl d be detached s State Dept. of | 20c. TIME OF INJURY Month, Day, Year 20d. INJURY DCCURRED 2De. PLACE DF INJURY (Home, farm, land) 20f. (Clty or town) (Count factory, street, office bldg., etc.) 20f. (Clty or town) (Count factory, street, office bldg., etc.) 20f. (Clty or town) 20 | (State) |
| NDIN ned Nuld It | 21. I certify that (I) (this hospital) attended the deceased from 4/16, 1947, to 4/16, 1967 | - C., 10, 111-1, 1-0. |
| ATTENDI retained ECTOR: A 3 should with the | saw the deceased alive on N. A. 19 , and that death occurred at 10 H.M. from the causes and on the | |
| AL OR lay be page appage filed v | Radaul A. Poron, UNO. M.D. ATTENDING MED. STAFF 14 G | pul 1967. |
| TO HOSPITAL OR ATTEND Page 4 may be retained TO FUNERAL DIRECTOR. 4 director, page 3 should should be filed with the | NAME (Type) RAFAEL A. BORGOS. 2101-16-5t., N. W., Washing | |
| Page Page Page Page Page Page Page Page | 233. BURIAL CREMATION, REMOVAL (Specify) Removal 4-19-1967 Woodlawn Cemetery Green Bay, Wisc. | |
| | 24. FUNERAL DIRECTOR ADDRESS 258. REC'D BY REGISTRAR 25b. REGISTRAR'S | SIGNATURE |
| VR A15 (4) 2DM 1/65 | GAWLER Masks. W. 6 JOATAPR 21 1967 Icharde | 2 Judge |



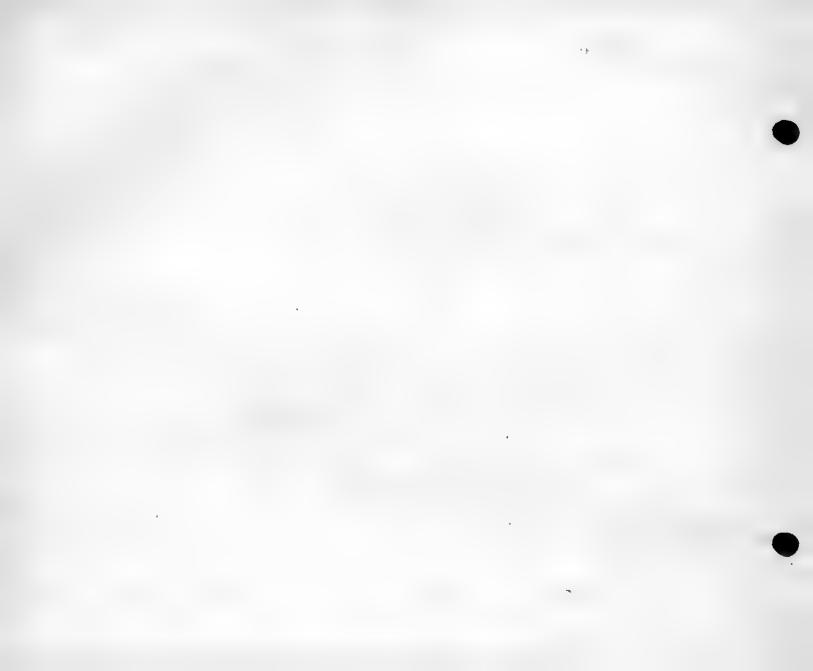
| - 1 | MARYLAND STATE DEPARTMENT OF HEALTH |
|--|--|
| 1 | DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND |
| # 727.4 | 05343 Item #7 Film #CERTIFICATE OF DEATH 05341 |
| hours after death. d in by the funeral rs. pegs 1 and 2 re. here after death. | 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) 3. COUNTY 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) |
| | MARYLAND MARYLAND |
| t fat | b. CITY OR TOWN (if outside corporate limits, write BURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (if outside corporate limits, write BURAL and give nearest town) |
| SI A | OS (15 - Septime and 15 to 100) |
| houn hou | d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS |
| executed within 24 ho n and completely filled i remove carbon papers. n any event/within 72 h | HOLI CZOS HOSPITAL - I.O.A. 1321/ STRUTTUL TOAD YES NO NO |
| thin tely on with | 3. NAME OF First . Middle Last 14 DATE Month Day Year |
| with plet | (Type or print) FRANCIS KILTIARF FLYNN DEATH aftell 11, 1967 |
| com | 5. SEX 6. COLOR OR BACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) Months Days Hours Min. |
| and | Months Days Hours Min. |
| eath certificate be ex attending physician an ermit. Then please rè on, or removal, and in à | 12. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRT HPLACE (Country & State, or foreign country) 12. CITIZEN OF WHAT |
| be sicial | during most of working life, even if retired) INDUSTRY: |
| ohys | 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME |
| tiffic ng p hen nov: | James Heling - Darch Marion - |
| ith cert ittendin mit. Th , or rem | A5. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address |
| e death c the atten if permit. Exami | (Yes, no, or unkown) (If yes give year or dates of service) |
| dea the a per trion | 18. CAUSE DF DEATH [Enter only one cause per fine for (a), (b), and (c).] |
| the y t nsit | PART I. DEATH WAS CAUSED BY: |
| sian Sian Sian trar Ca | IMMEDIATE CAUSE (a) COTTON CONTROL OF CONTRO |
| ulres that the deat sphysician. In signed by the at burial-transit perm burial, cremation, | Conditions, if any, which) DUE TO HYMER FEW Carterior Clerotic Carlowarent. |
| uire g pt en s en bu o bu | gave rise to immediate |
| requir ding p been the bi or to b | cause (a), stating the DUE TO (1) februar Poo Osica General Constant |
| ttendir has be as th prior | Underlying cause last. (c) CONTOURS TO THE TOTAL |
| M: The late or at tificate he for use for use for use thealth is ared | PERFORMED? |
| al called For Head | 20a, ACCIDENT WAS UNDERLYING 1 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) |
| | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM (NAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |
| rysici e hos his ce tache Dept. | |
| ###################################### | Hour a.m. While Not While factory, street, office bldg., etc.) |
| Sta Part Sta | |
| the the | 21. I certify that (I) (this hospital) attended the deceased from 15 + CC , 19 67, to 10 400, 19 62, that (I) (we) last saw the deceased alive on 19 67, and that death occurred at 2 400, from the causes and on the date stated above. |
| Eta Barrin | saw the deceased alive on 1967, and that death occurred at 2.4M, from the causes and on the date stated above. 22a. SUNATURE 22b. DATE SIGNED |
| Be 3 w Side | |
| Page file | |
| ERA TOT, | NAME (Type) |
| HOS age FUN rect | 23a. BURIAL CREMATION 23b. DATE THEREOF 23c. NAME OF CEMETERY OF CREMATORY / 23d. LOCATION (City, town or county) (State) |
| 2 2 5 4 | PREMOVAL (SPECIFY) 4/14/19/7 IT /11/24/1 / Secretary Colours Would The |
| AP | 24. FUNERAL DIRECTOR ADDRESS OF JULY 25a. REO'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE |
| VR A15 (4) | Of the The The 254 brashalles in ADD 19 1007 Vollander vides |
| 15M 4-64 | A INDIAMIL WHITE CONSTRUNGED TO CONTROL TO THE TO THE TOTAL THE TO |
| TO HOSPITAL Page 4 may Officetor, pag Should be fill | 22c. PHYSIGIAN'S NAME (Type) 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) REMOVAL (Specify) 4/14/1967 114/1967 |



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05344 CERTIFICATE OF DEATH and 2 death. OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death by the funeral Pages 1 and PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) COUNTY b. COUNTY oon papers. Pages I within 72 haurs after MARYLAND b. CITY OR TOWN (If outside porate I mit C LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside apropate limits, write RURAL and give nearest town) write RURAL on .⊑ (If not in haspital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? filled carbon NAME OF 4. DATE campletely DECEASED OF DEATH (Type or print) 9. AGE (In fears bothday) IF UNDER 1 YEAR S. SEX MARRIED **NEVER MARRIED** Manths X WIDOWED DIVORCED 11. BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT physician cremation, ar remayal, 15 WAS DECEASED EVER IN U.S. ARMED FORCES? INFORMANT 16. SOCIAL SECURITY NO (Yes, na or unknown) (If yes give war ar dates of service INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line burial-transit PART 1. DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (a DUE TO signed buriol Conditions, if ony, which gave rise to immediate cause (a), DUE TO stating the underlying cause be retained by the hospital ar attending be detached for use as the State Dept. af Health priar ta hos been PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO WAS AUTOPS PERFORMED? this certificate 2Da, ACCIDENT WAS UNDERLYING 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 2De. PLACE OF INJURY (Hame, farm, 20c TIME OF INJURY Month, Day, Year 2Dd INJURY OCCURRED (State) (C*y ar town) (County) Hour 'a m factory, street, office bldg., etc.) While Not While TO FUNERAL DIRECTOR: After 21. I certify that (I) (this hospital) attended the deceased fram Conc 19<u>07</u>, that (I) (we) last and that death accurred at 3:13PM, from causes and on the date stated above saw the deceased alive an 220 SIGNATURE **ATTENDING** M.D. PHYS DIRECTOR PHYS director, page shauld be filed 22d. ADDRESS TO HOSPITAL Page 4 may 1 22c. PHYSIC AN'S 218- WISCONSIN AVE N.W. WASH, D.C 230 BURIAL, CREMATION, 23c. NAME OF CEMETERY OR CREMATORY 23b. DATE THEREO! 23d LOCATION (City or Town) (County) 4-27-1967 Rock Creek Cemetery Washing VR A15 (4) 25M 1/67 Gawler 19



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21 CERTIFICATE OF DEATH 05345 The law requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY o. STATE **b.** COUNTY MARYLAND c LENGTH OF STAY IN 16 c. CITY OR TOWN, (If autside corporate limits, write RURAL and give newest town b. CITY OR TOWN (Il autside/carparate limits, write RURAL and dive near hours IS RESIDENCE ON A FARM? d NAME OF HOSPITA, OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS filled > Honoital YES NO Z NAME OF Middle DATE Manth completely OF DECEASED (Type or print) DEATH event remove car AGE (In years last birthday) IF UNOER SEX B. DATE OF BIRTH 6. COLOR OR RACE 7. MARRIED NEVER MARRIED Manths Days Haurs WIDOWED DIVORCEO remaval, and in any 10b. KIND OF BUSINESS OR 1). BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT No LSUAL OCCLPATION (Give kind of work done physician a en please I during most of working life even if refired) INDUSTRY COUNTRY? 14 MOTHERS MAIDEN NAME 13 FATHER'S NAME Un I mou 869 -Address Adair Plage 17 INFORMANT IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no ar unknown) (If yes give war or dates of service) ressie R. Fromas 25 3/25 crematian, 18. CAUSE OF DEATH (Enter only one cause per line for (\$\dagger\$), (b), and (c)) INTERVAL BETWEEN **burial-transit** ONSET AND DEATH PART : DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) signed by DUE TO burial Conditions, if any, which gave (b) rise to immediate cause (o), DUE TO stating the underlying cause O FUNERAL DIRECTOR: After this certificate has been of Health prior ta use as the 19. WAS ALTOPS'
PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO 209, DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part 1 ar Port II of item 18.) 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Home, form, (City or town) (State) 20c TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED (County) factory, street, office bldg., etc.) While Not While at wark ot wark be retained by . 1967 to 14 afre, 1967, that (1) (we) last 21. I certify that (I) (this hospital) attended the deceased fram 17 also 1967, to 18 also 1967, that (I) (we) last saw the deceased alive on also 1967, and that death accurred at 188 M, from causes and on the date stated above. saw the deceased alive on QAZ 10 22b. DATE SIGNED 22a SIGNATURE unc. W Callen DIRECTOR MD. PHYS 22d ADDRESS 22c PHYSICIAN'S CEDAR LANG. BETHESDA IND NAME (Type) 23d. LOCATION (City or Town) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (Stote) 23o. BURIAL, CREMATION, (County) REMOVAL (Specify) Pincoln Ceretery Privace Georges (2Sb. REGISTRAR'S SIGNATURE 250. REC'D BY REGISTRAR HEDATIA Avenue Ochanles Judge VR A15 (4) 20 M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 DEATH CERTIFICATE OF 95346 before admission) 2 USUAL RESIDENCE (Where deceased lived, if insist to 1. PLACE OF DEATH o. COUNTY o. STATE b. COUNTY Montgomery MARYLAND requires that the death certificate be executed within 24 hours after C LENGTH OF STAY IN 16 days c. CITY OR TOWN (If ootside corporate limits, write RURAL and give nearest town) IS RESIDENCE ON A FARM? d. STREET ADDRESS OR INSTITUTION (If not in hospital, give street address) 9201 NO X YES pan NAME OF M dd e DATE Month Year Lost Dov physician and campletely DECEASED April 79 19 67 (Type or print) DEATH IF UNDER 1 YEAR IF UNDER 24 HRS. S. SEX 6 COLOR OR RACE NEVER MARRIED DATE OF BIRTH AGE (In years 7. MARRIED lost birthdoy) Months Doys Hours WIDOWED DIVORCED Lei 10b. KIND OF BUSINESS OR 12 CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired) INDUSTRY Loyed COUNTRY? please and Dearborn

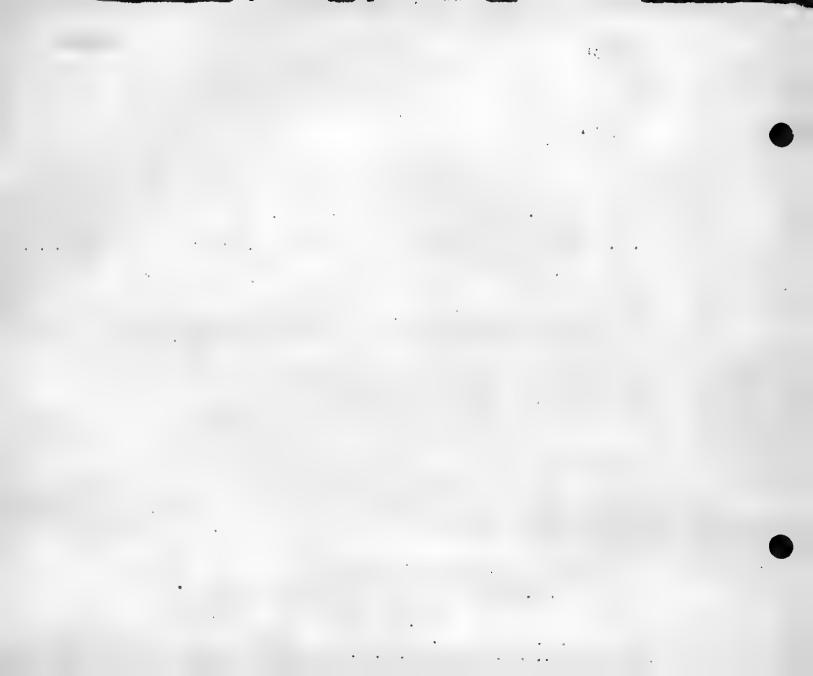
14. MOTHER'S MAIDEN NAME DWVOT 13. FATHER'S NAME or removal, Alice Layton Benton Gabbert WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT Adizo1 2nd Avenue (Yes, no or unknown) (If yes give wor or dates of service) Lewis Gabbert None Silver Spring NoCAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).
PART : DEATH WAS CAUSED BY. NTERVAL BETWEEN burial-transit ONSET AND DEATH IMMEDIATE CAUSE (o) signed by DUE TO Conditions, if any, which gove rise to immediate couse (a), DUE TO stoting the underlying couse as the TO FUNERAL DIRECTOR: After this certificate has been PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT WAS AUTOPS' PERFORMED? THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Stone NO P far 20o. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e, PLACE OF INJURY (Home, form, (City or town) (Stote) 20c. TIME OF INJURY Month, Dov. Year 20d INJURY OCCURRED 20f. (County) Hour o.m. foctory, street, office bldg, etc.) Not While of work of work , 19.6 7that (I) (we)-last 21. I certify that (1) (this_hasnital) attended the deceased fram_ 7 1967, and that death accorded at 2:45 AM, from causes and on the date stated above. saw the deceased alive an. 22b. DATE SIGNED 220 SIGNATURE ATTENDING PHYS. Za ZMO DIRECTOR PHYS director, page shauld be filed 22d ADDRESS 22c PHYSICIAN S Page 4 may NAME (Type) 1919 Seminary Rd., Silver Spring, Md. Rogers. 23c. NAME OF CEMETERY OR CREMATORY 230 BURIAL CREMATION 23b. DATE THEREOF 23d. LOCATION (City or Town) (County) REMOVAL (Specify) April Mt. Morah Cemetery Joseph. REC D BY REGISTRAR 8434 ADDRESS Averne VR A15 (4) 20 M 1/66 ilver spring

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| 1 | | MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | |
|--|----|--|--|
| (1) | 1) | CERTIFICATE OF DEATH 05345 | |
| er deoth funeral and er deom | | 1 PLACE OF DEATH a. COUNTY MARYLAND 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before a. STATE MARYLAND MARYLAND | re admission) |
| 24 hours ofter deoth ed in by the funerol ppers. Poges 1 and 3 | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give neares town) C LENGTH OF STAY IN 1b C CITY OR TOWN (If outside corporate limits, write RURAL and give neares town) | 50. |
| ecuted within 24 hours ofter deorth completely filled in by the funeral mye, carbon papers. Pages I and y event, within 72 hours after dearth | W | Potomac Valley nursing Home RT. # 1 THURSTON RD | e IS RESIDENCE ON A FARM? YES NO X |
| be executed within ond completely fille even ye carbon point only event, within | | 3. NAME OF DECEASED (Type of point) 5 SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED 1 8 DATE OF BIATH 9 AGE (In year & IF UNDER 1 YEAR | Year 19 6 7 IF UNDER 24 HRS. |
| 0 0 P 6 0 | • | MALE WIDOWED DIVORCED 12-8-1883 Jost birthday) Manths Days 10a JSUAL DCCJPATION (G ve kind of work dane 10b KIND OF BUSINESS OR 11 BIRTHPLACE (Ca.nty & State of fare an cauntry) 12 CIT ZEN O | Hours Min. |
| | | during most of working life, even if retired) 13 FATHER'S NAME OUNTRY 14. MOTHER'S MAIDEN NAME OUNTRY | 'U, S.A. |
| , 7 ○ ○□ □ E | | 15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dotes of service) (Yes, no, or unknown) (If yes give war or dotes of service) | 0. 1 |
| t the death the attendire sit permit. | | PART I. DEATH WAS CAUSED BY: | TERVAL BETWEEN NSET AND DEATH |
| deal Exemples that the physician. signed by the buriol-transit pur bur ol, cremation | | IMMEDIATE CAUSE (a) | 24M2 |
| w required by the burn or to burn | | rise to immediate cause (o), stating the underlying cause (c) DUE TO (c) | |
| | | PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDITION GIVEN IN PART 1(a) 19. Practure RV Itis Denlyalised Artemias love | WAS AUTOPSY PERFORMED? YES NO |
| ATTENDING PHYSICIAN: etained by the hospital or CTOR: After this certificate should be detached for util the State Dept of Heal | | Practure RV Hys Deneralized Anterialization of 1900 Describe How injury occurrence of injury in Part I or Part II of Itapi 18 } OR CONTRIBUTING CALSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER) Procture PCV Hip at Home in Pall 3/10/67 | |
| Wolve Physic dby the hospidal Affer this cert. db detoched estate Dept of | | 20c LIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e. FLACE OF INJURY (Hame, Drm, Hour a.m. 3 · 10 19 67 at wark at wark at wark at wark 20 at wark | (Stote) |
| | | saw the deceased alive on 4/2/ 19/1, and that death accurred at 2.75 M, fram causes and an the day | |
| AL OR ob be recorded by be recorded | | CamesWean ATTENDING MED. STAFF 4/21 | 167 |
| TO HOSPITAL OR ATTEND Poge 4 may be retained for FUNERAL DIRECTOR: A director, page 3 should should be filed with the book of the filed with the | / | 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d. LOCAT ON (City or Town) (County | y) (State) |
| OF C (4) | 2 | 24. FUNEPAL DIRECTOR ADDRESS 250 REC'D BY REGISTRAR 256 REGISTRAR'S SIGNATU | IRE |
| 25M 1/67 | U | Salamone tunical forme trederick Ted DAPR 24 1967 fillarles of | 6 |



| 1 | 1 | MARYLAND STATE Division of STATISTICAL RESEARCH AND RECORDS, | | PARTMENT OF HEALTH W. PRESTON STREET, BALTIMOI | RE. MARYLAND 212 | 01 |
|--|---------------|--|---------|---|--|--|
| | | | | OF DEATH | 053 | |
| ardeath. | | PLACE OF DEATH O. COUNTY Montgomery MARYLANI | D | 2 USUAL RESIDENCE (Where deceased in STATE New York | ved, if institution Residence b. COUNTY | e befare odmission) TLANP, |
| haurs aftern by the haurs aftern haurs aftern | | b CITY OR TOWN (II outside corporate limits, "Tellification" (errest town) 35 Days | | c CITY DR JOWN (If autside corparate lin | | neorest tawn) V |
| law requires that the death certificate be executed within 24 haurs a sading physician. been signed by the attending physician and campletely filled in by the state burial-transit permit. Then please remove carban papers. Paginar to burial, crematian, or removal, and in any event, within 72 haurs a | | d NAME DE HOSPITAL DR INSTITUTION (If not in hospital give street address) Naval Hospital | | d. STREET ADDRESS 47 Hubbard S | treet | e IS RESIDENCE ON A FARM? YES NO |
| physician and campletely filled in ten please remove carban papers. avai, and in any seeat, within 72 h | | NAME OF First Middle DECEASED (Type or print) JAMES ANTHONY | | GALUTZ 4. DATE OF DEATH | Manth APRIL | Day Year 20 19 67 |
| d camp | Ł | SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED MALE CAUC. WIDOWED DIVORCED | | June 14, 1946 2 | birthday) Months yrs | YEAR IF UNDER 24 HRS Days Hours Min |
| ate be cian an ease re | dur | USUAL OCCUPATION (Give kind of work done increased) 10b KIND OF BUSINESS OR INDUSTRY | | 1) BIRTHPLACE (County & State, or foreign Cortland, New Yo | TOU | ZEN OF WHAT NIRY? |
| physical phy | 13 | FATHERS NAME Anthony Galutz | | 14 MOTHER'S MAIDEN NAME Lena EX Piedi | amo a a d | |
| squires that the death certific physician. signed by the attending phys burial-transit permit. Then p burial, crematian, or remavai, | 1S (Ye | WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SDCIAL SECURITY ND 16 SDCIAL SECURITY ND | | NFORMANT | Address Address | |
| atte perm ian, a | H | IB. CAUSE OF DEATH (Enter only one couse per transfer of one of the one of th | | lavy Records | | INTERVAL BETWEEN |
| equires that the physician. signed by the burial-transit burial, cremat | | PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO | F H | EAD (Received as | a result | ONSET AND DEATH |
| quires tha physician. signed by burial-tran burial, crer | | Conditions, if ony, which gave) (b) of action in | Vi | et Nam) | | |
| The law requires the attending physician. has been signed by se as the burial-train hariar ta burial, cre | | rise to immediate cause (a), stating the underlying couse last. | | | | |
| : The irr afform afform the has | ATION | PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NDT RELATED |) 10 TI | HE TERMINAL DISEASE CONDITION GIVEN IN | PART I(a) | 19 WAS AUTDPSY PERFORMED? YES [X] NO |
| PHYSICIAN e haspital c nis certificat ritached far | CERTIFICATION | 20g. ACC DENT WAS UNDERLYING ☐ 20b DESCRIBE HOW INJURY OCCUR OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | RED (| Enter nature of injury in Part I ar Part II a | f item 1B.) | |
| OR ATTENDING PHYSICIAL be retained by the haspital DIRECTOR: After this certifica je 3 should be detached fa jed with the State Dept. af H | MEDICAL | 20c. TIME OF INJURY Manth, Doy, Year 20d INJURY OCCURRED 20c While Not While at work of work | facto | pry, street, office bldg., etc.) | y or town) (Cour | nty) (Stote) |
| TENDIN ned by NR: After ould be the Star | | 21 I certify that (I) (this haspital) attended the deceased fro saw the deceased alive an 20 APR 67.19 , and | | deoth occurred of 11A. M, fr | | |
| Page 4 may be retained Puge A may be retained Punckal DIRECTOR: A director, page 3 should should be filed with the | | 22a. SIGNATURE | M.D | ATTENDING MED. PHYS DIRECTOR | CTACC | TE SIGNED APR 67 |
| PITAL 1 may 1 ERAL D ar, pag d be fill | | 22c PHYSICIAN NAME (Type) D. K. ROEDER | | 22d. ADDRESS NAVAL HOSPITAL | - Belles | |
| TO HOSPITAL OR ATTEN Page 4 may be retained TO FUNERAL DIRECTOR: directar, page 3 should should be filed with the | 230 | REMEMBER 18 4-24-67 St. Marys | | emetery Cortl | and New Y | |
| VR A15 (4) 20 M 1/66 | | HOO Chapin St. N. W. Washington, D. C. | hors | 250. REC'D BY REGISTRAR APR 2 5 1967 | 25b REGISTRAR'S SIL | GNATURE |



papers. Pages I and 2 sin 72 haurs after death. 24 hours after death. pub ed in by the funeral opers. Pages I and

aw requires that the death certificate be executed within

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please remove car

attending physician permit. Then please

permit.

burial-transit

as the priar to b has been

signed by physician.

be retained by the haspital ar attending

this certificate ō

O FUNERAL DIRECTOR: After

Page 4 may

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) PLACE OF DEATH MARYLAND CLENGTH OF STAY IN 16 c CITY OR TOWN (If outside corparate limits, write RURAL and give negrest town) e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS YES [NO X NAME OF Middle DATE Doy Year DECEASED LARRY 19 6 DEATH (Type or print) S SEX AGE (In years 1 YEAR IF UNDER 24 HRS 6 COLOR OR RACE MARRIED NEVER MARRIED DATE OF BIRTH tast birthday) Months Days Haurs WIDOWED DIVORCED 10a, US, JAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 12 CITIZEN OF WHAT II. BIRTHPLACE (County & State, or foreign (auntry) during most of working life, even if retired) INDUSTRY COUNTRY? Housewife 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME WAS DECEASED EVER IN J S ARMED FORCES? 17. INFORMANT dushahd Address (Yes, no, ar unknown) (If yes give war or dates of service) Same as Item George L. Gilbert 18. CAUSE OF DEATH (Enter only one cause per line for (a) INTERVAL BETWEEN PART I DEATH WAS CAUSED BY-IMMEDIATE CAUSE (a) DUE TO Canditians, if any, which gave rise to immediate cause (a). DUE TO stating the underlying cause lost. WAS AU PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO 20g. ACCIDENT WAS UNDERLYING 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I ar Part II of item 18) OR CONTRIBUTING [7] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e, PLACE OF INJURY (Hame, farm, 20c, TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED (City or town) (County) (State) Haur a.m. factory, street, office bldg., etc.) Not While 21. I certify that (1) (this hespital) attended the deceased fram 4 -Z, and that death occurred at 1/1/2 29M, from causes and an the date stated above saw the deceased alive an 22b. DATE SIGNED 22a SIGNATURI **ATTENDING** M.D. PHYS. 22d. ADDRESS 22c. PHYSICIAN S NAME (Type) 8025 ABERDEE 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (State) 23g. BURIAL CREMATION 23b. DATE THEREOF (County) Burlal Specify) West Plains. Howell Mem. Missouri 4-15-67 Park 24. FUNERAL DIRECTOR PUMPHREY, Bethesda, Maryland

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

| _ | 05350 MEDICAL EXAMINER'S | CERTIFICATE OF DEATH 05348 |
|---------------|--|--|
| 1. | PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE b. CDUNTY Montgomery |
| | b. CITY DR TOWN (If outside corporate limits, write RURAL end give nearest town) Silver Spring. Md. | c. city DR TOWN (If outside corporete limits, write RURAL and give nearest town) Silver Spring |
| | d. NAME OF HOSPITAL OR INSTITUTION (If not In hospital, give street address) | d. STREET ADDRESS 415 Silver Spring, Ave Apt.309 ves No. 18 RESIDENCE ON A FARM? ves No. 18 RESIDENCE ON A FARM? |
| 3. | NAME DF First Middle DECEASED (Type or print) William Joseph | Lest 4. DATE Month Day Year OF 4-21-67 19 |
| | Male White WIDOWED DIVDRCED | 8. DATE OF BIRTH 9. AGE (In years IFUNDER 1 YEAR IFUNDER 24 HRS. Months Days Hours Min. Min. |
| Gu | o. USUAL DCCUPATION (Give kind of work done industry) Ing most of working life, even if retired) o. tract (glicer U.S. Gout. | 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT CDUNTRY? 14. MOTHER'S MAIDEN NAME |
| d'y | es, no, or unkown) (If yes give way or dates of service) | Elle Donaher INFORMANT INFORMANT IMAGE !! Address Image !! Pesta root Image !! Pesta roo |
| | 18. CAUSE DF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE GAUSE (a) DUE TO | goes Dir Colorer Interval Between DNSET AND DEATH |
| | Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO | |
| CERTIFICATION | PART II. DTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELA | (TED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(4) 19. WAS AUTOPSY PERFORMED? YES NO |
| | 20a. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCU PRIMARY ☐ or CDNTRIBUTING ☐ CAUSE OF DEATH. | IRRED. (Enter nature of injury in Part I or Pert II of Item 18.) |
| MEDICAL | | CE DF INJURY (Home, farm, 20f, (City or town) (County) (State) ry, street, office bidg., etc.) |
| | | cide, Homicide, Undetermined manner CHIEF MEDICAL EXAMINER |
| | | M.D. ASSISTANT MEDICAL EXAMINER 22. DATE SIGNED DEPUTY MEDICAL EXAMINER 12 |
| 23 | EXAMINER'S John S. Rogers, M.D., 1919 Semina Burial, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY | |
| 5 | REMOVAL (Specify) Apr 25, 1967 St. Sohn Co | eretery Worcester Mass |
| 7 | TENNERAL DIRECTOR Collection Silver Specia August Solver Specia August Silver Spring | 25a, REC'D BY, REGISTRAR 25b, REGISTRAR'S SIGNATURE |



| 1 | MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND |
|---|--|
| 7 2 505 | 05351 CERTIFICATE OF DEATH 15349 |
| death uneral and 2 death. | PLACE OF DEATH a. COUNTY a. COUNTY a. COUNTY |
| | MENTGEMERY MARYLAND MENTGEMERY |
| in the first in the safes I hours after | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHEATEN C. LENGTH OF STAY IN 1b C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SIVER SPRING |
| hou hou ers. | d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE |
| n 24 h y filled papers | MINERSITY NORSING HOME 806-MALCOLM DRIVE YES NOW |
| l within upletely carbon ent, with | 3. NAME OF DECEASED (Type or print) Blanche Gold Devg 4. DATE Month Day Year 1967 |
| te be executed within 24 ho hysician and completely filled i please remove carbon papers. | 5. SEX 6. COLOR OR BACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years IF UNDER 14 PAR IF UNDER 24 HRS. Hours Min. Hours M |
| be ey ician a ase re | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR III. BIRTHPLACE (County & State, or foreign country) 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? |
| phys | 19. FATHER'S NAME |
| ertifi Jing Ther emon | ABRAHAM SOLOMON AMELIA DURNING |
| eath c atten ermit. m, or r | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) (If yes give war or dates of service) 459-86-3525 MRST. N. FRIEDMAN - 806-Malcelm-DR, 5,5, |
| t the d an. I by the ansit p | PART I. DEATH (Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) NOCARDIAL (WFARTTON) INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE CAUSE (a) |
| ATTENDING PHYSICIAN. The law requires that the death certificate be retained by the hospital or attending physician. ECTOR. After this certificate has been signed by the attending physician should be detached for use as the burial-transit permit. Then please with the State Dept. of Health prior to burial, cremation, or removal, and in | Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO ARTERIO SCIQUETIC Heavy Disease 10 years (b) DUE TO (c) |
| The lay or attocate has a ruse a ealth pi | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |
| PHYSICIAN: the hospital this certifical detached followed a Dept. of H | 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |
| NG PHYS by the h fter this be detac | 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 4 work 20f. (City or town) (County) (State) |
| OR ATTENDIN OR ATTENDIN P be retained b OIRECTOR: Att OIRE 3 should b led with the St | 21. I certify that (ii) (this hospital) attended the deceased from |
| Ped es | 22c. PHYSICIAN'S 22d. ADDRESS 22d. ADDRESS |
| O HOSPITAL Page 4 may O FUNERAL director, pa | NAME (Type) MCR+CN SHAPIRC 81C7-EAS+ERN, AVE-5, S, MD 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) |
| 5 DT 1948 | 23a. BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) BUTI al 4/19/67 Natchez Cemetery Natchez, Mississippi 24. FUNERAL DIRECTOR / ADDRESS 125a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE |
| VR A15 (4) | B Eangansky & Sons, 3.501-146 St NW DATAPR 18 1967 yourses Judge |
| 15M 4-64 | DAIL! II I O IOOI |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the director, page 3 should be detached for use as the burial-transit permit. Then please Temove carbon papers. Pages I should be filed with the State Dept. of Health prior to burial, cremation, or removal, and the ayevent, within 72 hours after

| | MARYLAND STATE DEPARTMENT OF HEALTH | |
|------------------------|--|-----------------------|
| DIVISION OF STATISTICA | AL RESEARCH AND RECORDS, 301 W. PRESTON STREET, | BALTIMORE 1, MARYLAND |
| 05352 | AL RESEARCH AND RECORDS, 301 W. PRESTON STREET, CERTIFICATE OF DEATH | U 5 350 |

| | 1. | PLACE OF DEATH a. COUNTY Montgomery AMADYLAND | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE b. COUNTY Mon 49 |
|---|---------------|--|---|
| | _ | b. CITY OR TOWN (If outside corperate limits, c LENCTH OF STAY IN 1b | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) |
| i | | write RURAL and give nearest town) | CI O mal |
| | _ | d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | d. STREET ADDRESS . e. IS RESIDENCE |
| · | | 10213 Mckenney Ave | 10213 Mc Kenney Ave VES NO M |
| | | | ORKA JATE Month Oay Year OF DEATH ADF 1967 |
| | 5. | THE THE MANAGED AND THE PER MANAGED | 8. DATE OF BIRTH July 30 1896 9. ACE (In years IFUNDER 1 YEAR FUNDER 24 HRS. Months Days Hours Min. Min. |
| | 10a | USUAL OCCUPATION (Give kind of work done 10b. KING OF BUSINESS OR INDUSTRY INDUSTRY | 11. BIRTHPLACE (County & State, or fereign country) 12. CITIZEN OF WHAT COUNTRY? |
| | Pe | t. Chet Kammels Restauran | 1 100134001 |
| | | FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
| | | Paul Gorka | Ludwika Gorka |
| | | S. Do. of Hekown) (If we nive war or dates of corplice) | INFORMANT Address? Co Newsy Tue. |
| | , | No June 578-01-736:4 M | rs Florence GORKA C. I Same |
| | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | INTERVAL BETWEEN |
| | | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) COFON A CY | Oce Usion Onset and Ocath |
| | | DUE TO | |
| | | Conditions, If any, which) (b) Coronary | insufficiency 645 |
| | | gave rise to immediate cause (a), stating the DUE TO | 17 |
| | _ | underlying cause last. (c) | |
| 2 | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUTNOT RELA | TED TO THE TERMINAL DISEASE CONDITION CIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? |
| | FICA | | YES NO 🔀 |
| | CERTIFICATION | 20a. ACCIOENT WAS UNDERLYING 20b. OESCRIBE HOW INJURY OCCU OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | RRED. (Enter nature of Injury in Part I or Part II of Item 18.) |
| | MEDICAL | | CE OF INJURY (Home, farm, 20f. (City or town) (County) (State) |
| | NED | Hour a.m. While Not While facto | y, street, onice blug., etc., i |
| | 900 | | man 1967, to Gar 18, 1967, that (1) (we) last |
| | | | death occurred at TimAM, from the causes and on the date stated above. |
| | | 22a. SIGNATURE | 22b. DATE SIGNED |
| | | yenn Lawrence levery M.O | |
| 1 | | 22c. PHYSICIAN'S NAME (Type) Och La revoce Avery | 10620 Georgia Ave. Silver Spring Md. |
| | 23a | BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY | OR CREMATORY 23d. LOCATION (City, town or county) (State) |
| | | Suria: Apr 22, 1967 Glenwood Cense | ctery Washington D. C. |
| | 24 | John De TO 30 Selling Shares 434 4:000 a Au | 25a. REC'O BY RECISTRAR 25b. REGISTRAR'S SICNATURE |
| | 7(1 | Je E. M. D. Ley, C. C. Silver Surana | Md DAJEUR 2 G 1967 y Charles Judge |
| | | | |

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medical examiners office notified Ifle

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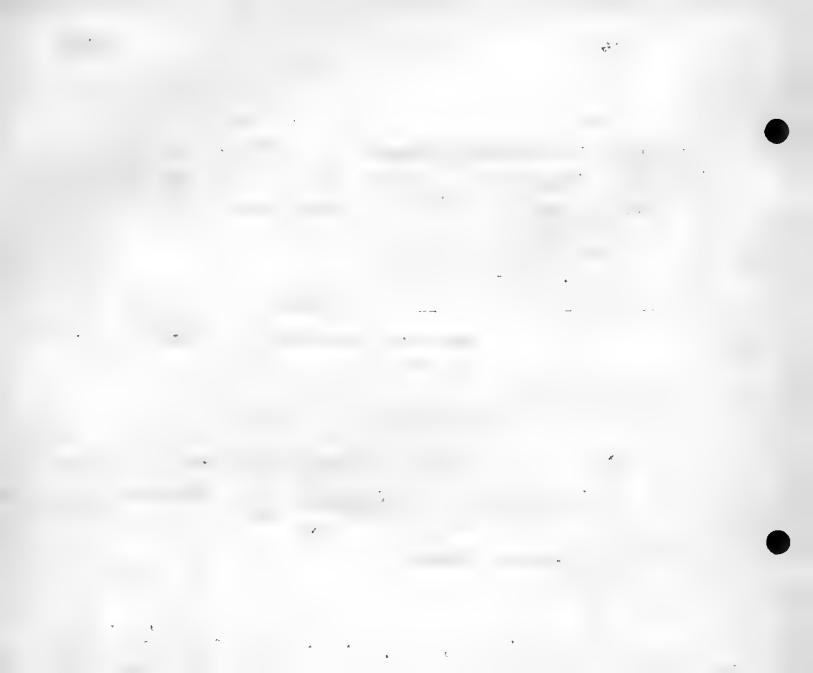
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Itams 10a &B, 11, 12, 1 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE 05353 PLACE OF DEATH HEALTH DERT 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a COUNTY a. STATE **b** COUNTY 0 Mintyimery MARYLAND delay and 3 t c. LENGTH OF STAY IN 16 (If outside corporate limits autside corparate limits, write RURAL and give nearest tawn and M3. write EURAL and give nearest town) Bethosola Chevy Chased. NAME OF HOSPITA. OR INSTITUTION (18 nat in haspital, give street address) d STREET ADDRESS e IS RESIDENCE he certificate, mir ting the word "mending" in pencl in Item 18. Give Pages 1, should be forwarded to the Chief Medicol Examiner's Office along with form ON A FARM? ,1 NO 🔀 in Item 18. Give Poges hours ofter death NAME OF Midd e DATE Day Year DECEASED # # Icls 1967 ebora Jranger (Type or print) DEATH S SEX 7 MARRIED T B DATE OF BIRTH AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 6 COLOR OR RACE NEVER MARRIED lost birthday) Manths Hours JUNE 28,1932 DIVORCED event within 72 hours after death WIDOWED 10a USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (State or foreign country) 12 C TIZEN OF WHAT during most of working life, even if retired) INDUSTRY **COUNTRY?** Easton, Mass. This cert f.cate should be executed within 24 Housewife Mousewife

13. FATHER'S NAME U.S.A. 14. MOTHER'S MAIDEN NAME Newlin D. Wildes Faith Lovel IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO INFORMANT (Yes, no, or unknown) (If yes give war ar dates of service) INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: aceration & Maceration of Brain IMMEDIATE CAUSE (a) DUF TO in ony Gun Shot. Wound of Head. Conditions, if ony, which gave rise to immediate couse (a). DUE TO stoting the underlying couse nsed PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY removol, FICATION PERFORMED? NO pe 20a EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Part II of item 18) 3 shauld PRIMARY OF CONTRIBUTING CAUSE OF DEATH 5 Self in Rtside of head with derringer 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame, form, 20c TIME OF NIJRY Manth, Doy, Year (City or town) (County) (State) factory, street, office bldg., etc.) Not While et hesda Montgomera Mo at work Inspect on 2) I certify that I taak charge of the remains described above, held an Autapsy and in my apinion FUNERAL DIRECTOR: death resulted fram: Natural causes Accident Suicide X Homicide Undetermined monner be retained CHIEF MEDICAL EXAMINER Drior to ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE funeral DEPUTY MEDICAL EXAMINER EXAMINER'S , 5 may TO FUNE Health Address (Street, city, town, or county) NAME (Type) He 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23a BURIAL CREMATION. 23b DATE THEREOF (County) cremation Suitland Cedar Hill Crematory 5130 Wi 24 FUNERAL DIRECTOR VR A15ME (5) ocharles Judge Joseph Gawler's 6M 1/67



CERTIFICATE OF DEATH 05354 Rea. Dist. No. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission o. COUNTY o. STATE **b** COUNTY Montgomery, MARYLAND b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rurat ond give represt town)
Silver Spring davs Washington. d. NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS IS RESIDENCE
ON A FARM? OR, INSTITUTION Bethesda-Silver Spring Nursing 4422 YES NO Y Street NAME OF Middle 4. DATE Month Day Year DECEASED OF DEATH (Type or print) April 6 Marv 19 S. SEX 6. COLOR OR RACE 7. MARRIED T NEVER MARRIED 8. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS 9. AGE (In years last birthday) Months Apr. 18.1871 WIDOWEDX DIVORCED | emale White 10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Stote or foreign country) 12 CITIZEN OF WHAT COUNTRY? wife Dist. of Col. House U.S. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Wallace Robert DeLav 15 WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Grand-Daughter Address Logan E. Hill Wash. 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (O) **DUE TO** Conditions, if any, which gave rise to immediate DUE TO cosse (o), stating the underlying couse lost. PANT II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(p) 19. WAS AUTOPSY PERFORMED? 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b, DESCRIBE HOW INJURY OCCURRED, (Enter noture of injury in Port I or Port II of item 18.) 20e. PLACE OF INJURY (Home, form, 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20f. (City or town) (Stote) (County) foctory, street, office bldg., etc.) Hour o. m. While Not while of work p. m. 21. I certify that I attended the deceased from 22.2 Lithat I last saw the deceased and that death occurred at SHPM, from the causes and on the date stated above. ADDRESS (Street, city or town, state DATE SIGNED PHYSICIAN'S NAME (Type) 220. BURIAL CREMATION. 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) (Stote) REMOVAL (Specify) Cedar Hill Cem. Georges Co. 23. FUMERATIDIRECTOR'S SIGNATURE 24a, REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Melarles DATE

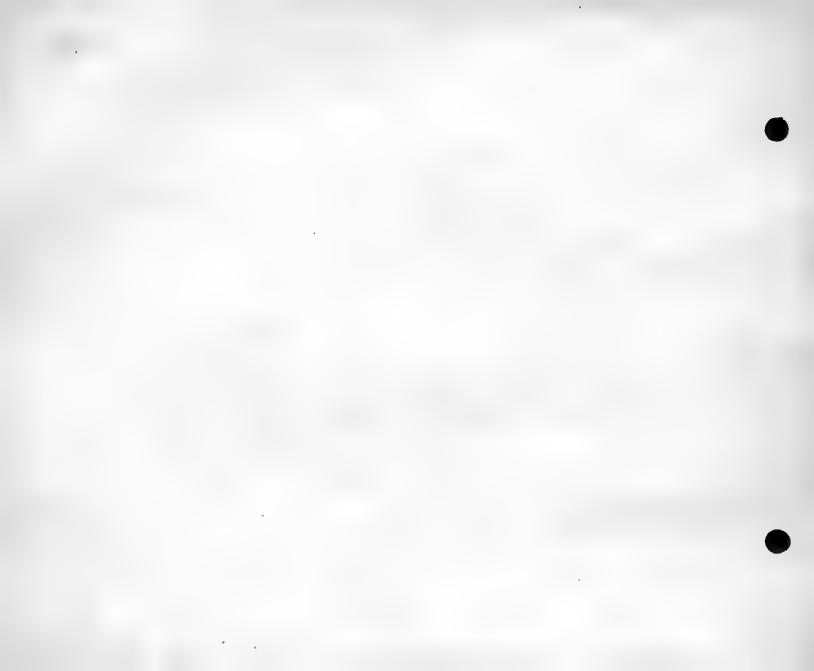
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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| · | AX | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORI | | nenen |
| 2 | FOR STATE) | | 05355 MEDICAL EXAMINER'S CERTIFICATE OF | DEATH | 05353 |
| of . | HEALTH DEPL | | PLACE OF DEATH 2 USUAL RESIDENCE (When I Shall Be a Sh | ere deceosed lived, if institution: F | Residence before admission) |
| | ay is 3 to age | | MARYLAND ///WWW. | und 1100 | nlgomery |
| | f a.ry delay is 1, 2, and 3 to rm PM3. Page Department of | | WATE KUKAL CITC GIVE RECESS TOWN! | de corporate limits, write RURAL o | and grae nearest towny |
| 4 | Ph Ph | | J a Roma (Tark) DO /T Jakoma NAME OF HOSPITA, OR INSTITUTION (Final psychospital, give street oddress) d. STREET ADDRESS | - Jane, | e IS RESIDENCE |
| | v 0 v | | Washington San + Hask. 4 Dome | rave. | YES NO |
| | 24 hours after deoth. I in Item 18. Give Poges r's Office along with for set 1 and 2 with the state of the record | 3 | NAME OF Jelen First a. Middle Lost (Special Lost) | 4. DATE Month OF DEATH | Doy Year 28 1967 |
| | after 8. Giv olong with | S. | | | UNDER I YEAR IF UNDER 24 HRS |
| | hours of them 18 Office of 1 and 2 vir death | | F WIDOWED DIVORCED 2-21-11 | -56 Yrs | |
| | 24 hours in Item 1 r's Office es 1 and 2 offer death | dur | USUAL OCCUPATION (GIVE kind obwork done ng most b) working life, even if mired) 10b. K ND OF BUSINESS OR INDUSTRY | | 12 CITIZEN OF WHAT COUNTRY? |
| | within 24 hours pencil in Item 18 xaminer's Office of ile poges Land 2 v hours after death | 13. | FATHER'S NAME Lucke 14. MOTHER'S MAIDEN NAM | Know | |
| | s, vertificate should be executed within 24 hours s, writing the ward "pending" in pencil in Item 1 forwarded to the Chief Medical Examiner's Office used as a burial-transit permit. File pages 1 and 2 loval, and in any event within 72 hours after death | 15 (Ye | was Deceased Ever IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17 INFORMANT St. Down of dotes of service) | Halyar Ran | ne as #2) |
| | exe endii Me if pe | | 18 CAUSE OF DEATH (Enter only one couse per line for (o) (b), ond (c)) PART I. DEATH WAS CAUSED BY- | 0/ | INTERVAL BETWEEN ONSET AND DEATH |
| | should be e ne word "per to the Chief I burial-transit | | IMMEDIATE CAUSE (a) ACUTE INTRACTAILAT HEMOTI | chage | Oliset Mile Servin |
| | should the Ch the Ch urial-tre | | Conditions of any which cause | | |
| | the shape of the s | | tollings, it only, which gove the state of the underlying couse (b). Storing the underlying couse (b) to the underlying couse (c). | | |
| | vertificate sh writing the rwarded to sed as a bu val, and in a | | lost (c) | | |
| | This certificate should cate, writing the word be forwarded to the Cl lee used as a burial-trremoval, and in any every | MO | PART II OTHER S GNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDI | FION GIVEN IN PART I(o) | 9. WAS AUTOPSY PERFORMED? |
| | This cert icate, wri be forwa be forwa removal, | CERTIFICATION | 200 EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Por | the Part II of Jam 18 | YES NO |
| | 두 프로 | | PRIMARY Or CONTRIBUTING CAUSE OF DEATH | · | |
| | | MEDICAL | 20c TIME OF INJURY Month, Doy, Year Hour a m 19 | 20f (City or town) | (County) (State) |
| | L EXA cerute Poge far you R: Pag | | | Inspect on 🔲 , Inquiry | VEN |
| | se exector Porton Porto | | death resulted from: Natural causes 🗷 Accident [2], Suicide [2], Homicide [| , Undetermined mann | er 🔲 |
| | JTY MEDIC, Iny, please e erol director be retained RAL DIRECT prior to buri | | ACTUAL SIGNATINE ACSISTANT MEDICAL EX ASSISTANT MEDICAL | | , 22. DATE SIGNED |
| | SSary, plicand of the prior the prior the prior | | EXAMINED.C | EXAMINER A | 28/19/7 |
| | TO DEPUTY MEDICAL EXAM necessary, please execute the funeral director. Page 4 5 may be retained far your to FUNERAL DIRECTOR: Page Health prior to burial, crema | | NAME (Type) /3 ELDEN/ K, KEAP, M. (), BODIES NEWS | ny town or county) | 10///0/ |
| | TO DEPU necessal the fune 5 may b TO FUNER Health | 230 | But 3.1967 Lakeriew-Cemiling | 23d LOCATION (City or fown) | New Gorf |
| | VR A15ME (5) 6M 1/67 | 3 | EUNERAL D RECTOR Selve 254 Carroll DLNW. Wash W DATE MAY | | rar's signature (|



| 1 | - 1 | 1 | Division of STATISTICAL RESE | MARYLAND STATE DEI ARCH AND RECORDS, 301 | | | AND 21201 |
|----------|---|----------|---|---|---|--|---|
| | . 2 . | | 05356 | CERTIFICATE | OF DEATH | | 05354 |
| | ptter. death | | PLACE OF DEATH O. COUNTY MONTGOMERY | MARYLANO | o. STATE Marvlar | od M | fontgomery |
| | | | b (ITY OR TOWN (If outs de corporate limits, word TUPAL Red SYP RETRICIONN) | c. LENGTH OF STAY IN 16 1 Hour | CITY OR TOWN (If outside Silver | corporate limits, write RUR | AL and give nearest town) |
| | in 24 ho filled in papers. hin 72 ho | | d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, Holy Cross Hospital | g.ve street oddress) | d. STREET AODRESS Kin | toss | e IS RESIDENCE ON A FARM? YES NO |
| | ed within | | NAME OF DECEASED (Type or print) William M SEX 6 COLOR OR RACE 7, MARRIED | Middle atthew Hanl NEVER MARRIED E | LOST 4. | DATE Month OF DEATH Apr 9. AGE (tn years | |
| | and cam remove in any ev | 100 | Male White WIDOWED | OIVORCED I | 7-16-84 11. BIRTHPLACE (County & Sto | lost birthdoy) 82 yrs. | Months Ooys Hours Min. 12 CITIZEN OF WHAT COUNTRY? |
| № | physician en please oval, and i | | Retired Insurance Agent FATHER'S NAME | NDUSTRY Insurance | Louisvill 14 MOTHER'S MAIDEN NAME | | USA |
| IN ER/ | e Ferrie | 15 (Y | est no, or unknown) (If yes, give wor or dates of service) | | Catherine NFORMANT Villiam L. Han | Addres | S Lexington Dr.SS |
| EXAMINER | that the deatl an. by the attendi Iransit permit. Gremation, or r | - | IB CAUSE OF DEATH (Enter on y one couse per line for | 7 70 2171 | 0.1.0 | arction | INTERVAL BETWEEN ONSET AND DEATH |
| MEDICAL | physician physician signed by the burial-transit burial, cremai | | Conditions, if any, which gove (b) | yocardia/ | insufficie | ney | 1 year |
| | | | stoting the underlying couse DUE 10 (c) Ar / | terioscherotic | | cardiovasc. | |
| WITH | N: The ar att are that use r use eafth g | FICATION | PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING 200 ACCIOENT WAS UNDERLYING 205. D | ESCRIBE HOW INJURY OCCURRED. (| | | 19. WAS AUTOPSY PERFORMED? YES NO |
| | 日も生っち | CERT | OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | E OF INJURY (Home, form, | 20f (City or town) | (County) (Stote) |
| CLEARED | DING PHYS by the has lifter this ce be detache State Dept. | MEDICAL | Hour a.m. While | e Not While focto | ory, street, office bldg., etc.) | 35-10April 1, | , 1967, that (I) (we) last |
| • | or ATTENI be retained DIRECTOR: A ge 3 should led with the | | saw the deceased alive an April 220 SIGNATURE | 19 <u>6.7</u> and that | ATTENDING - MED | M, from causes of | and an the date stated above. 22b. DATE SIGNED |
| | AL 1 AL 1 | | 22. PHYSICIANS NAME (Type) Raymond Bradsh | radshaw, MC | 22d. ADDRESS 345 Univer | STAFF DECTOR DESTAFF DECTOR DESTAFF DECTOR DESTAFF DECTOR DESTAFF DECTOR DECTOR DECTOR DECTOR DESTAFF DECTOR DESTAFF DECTOR DECT | 5.5. Md. |
| | Page 4 may O FUNERAL director, pag should be fil | 1 | BURIAL CREMATION, 23b DATE THEREOF Apr 5, 1967. | 230 NAME OF CEMETERY OR O | REMATORY | 23d. LOCATION (City or Tov | |
| | VR A15 (4) √ 20 M 1/66 | 1/1/2 | FUNERAL PIRECTO THOMAS John Blown | 8434 Georgia A | venue 250 RECD BY | | GISTRAR'S SIGNATURE |



| 1 | Items 18-21 Film 388 5-2 MARY LAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | |
|--|--|-------------------------------------|
| FOR STATE | 95357 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 0535 | 65 |
| HEALTH DEPT. | PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institut on Residence by O. STATE b. CQUNTY MARYLAND | MERU |
| PM3. de | write RURAL and give nearest town) TAKOMA NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address) d NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address) d STREET ADDRESS | e IS RESTDENCE ON A FARM? |
| orth IF Cry ages 1, 2 lith farm P State Depa | | YES NO Year |
| after death 8 Give Pagi alang with with the Sta | Comparison Com | |
| haurs of Item 18 Office a Land 2 w | 100 USUAL OCCUPATION (Give kind of work dane 10b KIND OF BUSINESS OR 11 BIRTHPLACE (State ar fareign country) 12 CITIZEN Guring most af warking life, even if refixed) (NDUSTRY) | OF WHAT |
| ithin 24 haurs encl in Item I miner's Office pages land 2 ours after death | during ost of working life, even if retired ARMY ARMED FURCES ILLINOIS 13 FATHER'S NAME DAVID HARDIN CORA | J. /r |
| executed without on on one of the within 72 hou | 15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, np, or unknown) (If yes g va war or dates of serv ce) WWITE V ROCKA 315 10 0052 S.S. POLICE & MRS L. HARDIN | (WIFE) |
| This certificate shauld be executed within 24 haurs after death. If the cate, writing the ward "pending" in penal in Item 18 Give Pages 1, be farwarded to the Chief Medical Examiner's Office along with farm the used as a burial-transit permit. Fle pages land 2 with the State Defermand, and in any event within 72 hours after death | | INTERVAL BETWEEN ONSET AND DEATH |
| ficate shau ng the wo ded to the as a burial and in any | Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) apparently self-inflicted DUE TO (c) | |
| This certificate, writh all be farward and be used a ar remayal, ar | PART II OTHER SIGNIFICANT CONDITIONS CONTRIBITING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(c) | 19 WAS AUTOPSY PERFORMED? YES NO |
| <u> </u> | 200 EXTERNAL CAUSE WAS | |
| XAMIN te the ye 4 sh yaur fil yaur fil age 3 s | pm. 1 = 10 17 07 at work at work 2 | |
| MEDICAL EXPlores executive director. Page etamed for your police. | 21. i certify that I taak charge of the remains described above, held an Autapsy (Inspection (Inquiry | and in my apinian |
| · | SIGNATURE SIGNATURE ASSISTANT MEDICAL EXAMINER DEPUTY MANY ASSISTANT MEDICAL EXAMINER 4/18/ | 22. DATE SIGNED |
| necessary, processary, process | NAME (Type) QC QC A Add A Mittel, CAY County) 230 BURIA' CREMATION, 23b DATE THEREOF 23c NAME OF CEMETRY OR CREMATORY 23d LOCAT ON (City or Town) (County) PENOVAL (Specify) 23d LOCAT ON (City or Town) (County) | ιρ(γ) (State) |
| VR A15ME (5) 6M 1/67 | Surface Walters 254 Carral Alin. OC 250 PR Day geology 250 Carral Alin. OC Date | ingenial . |

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 95358 CERTIFICATE OF DEATH law requires that the death certificate be executed within 24 hours after death. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. COUNTY a. STATE b COUNTY MARYLAND the attending physician and campletely filled in by the sit permit. Then please refrese carban papers. Pages b CITY OR TOWN (If outside corparate imits, r LENGTH OF STAY IN 16 c CITY OR TOWN (Ly outside corporate limits, write RURAL and give nearest town) van papers. Pag within 72 haurs d. STREET ADDRESS IS RESIDENCE ON A FARM? d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) YES □ NO corban 3 NAME OF Middle Lost DATE Doy Year DECEASED OF DEATH (Type or print) 19 S SEX IF UNDER YEAR IF UNDER 24 HRS please reference 6 COLOR OR RACE 7. MARRIED NEVER MARRIED DATE OF BIRTH (In years birthdoy) lost Manths Dovs Hours and in any WIDOWED DIVORCED 10a, USUAL-OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 12 CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) during most al working life, even if refued) INDUSTRY of tille 13 FATHER S NAME 14 MOTHER'S MAIDEN NAME crematian, ar remayal, 3000 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. INFORMAN? (Yes, na, ar unknown) (If yes give war or dotes of service INTERVAL BETWEEN ONSET AND DEATH 18. CAUSE OF DEATH (Enter only one rouse per lipe_far (o), (b) and (c)) burial-transit PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) À be retained by the hospital ar attending physician. **DUE TO** bangis burial Canditians, if any, which gave rise to immediate couse (a), **DUE TO** as the prior tal stating the underlying couse this certificate has been lost. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH-BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) YES 4 -NO ō 20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 205. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port II of Item 18.) 4 detached (IF EITHER NOTIFY MEDICAL EXAMINER) State Dept. 20c TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour om factory, street, office bidg., etc.) Nat While After of work at wark þe 21. I certify that (I) (this hospital) attended the deceased from. 19 67 to 1961, that (I) (we) last 3 should to with the S and that death occurred at 6 2 M, from couses and on the date stated above. 723 O FUNERAL DIRECTOR: saw the decaased olive an 2 19 67 22a. SIGNATURE 22b. DATE SIGNED **ATTENDING** M.D DIRECTOR PHYS PHYS r, page be filed 22d. ADDRESS 01d Georgetown Rd. 22c. PHYSICIAN'S Page 4 may Robert G. Brewer NAME (Type) Maryland Bethesda director, should b 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 230, BURIAL, CREMATION, 23d. LOCATION (City or Town) (County) (Stote) Burial Washington 4-26-67 Rock Creek Cemetery Bethesda, 24 FUNERAL DIRECTOR VR A15 (4) 20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH



DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 95353 The law requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. COUNTY a. STATE **b.** COUNTY MARYLAND Pages b. CITY OR TOWN (If outside corporate limits, C LENGTH OF STAY IN 16 c CITY OR TOWN (If autside corporate limits, write RURAL and give nearest tawn) event, within 72 haurs ≘ papers d STREET ADDRESS IS RESIDENCE YES NO EX 3 NAME OF carban Year DECEASED OF DEATH 1960 (Type or pant) F UNDER 1 YEAR 6. COLUR OR RACI MARRIED NEVER MARRIED AGE HE years last bythagy) Manths Days Haurs of any WIDOWED DIVORCED and during most of working life even if retired) 10b KIND OF BUSINESS OR 12 CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) COUNTRY? Celou Ca 13. FATHER'S NAME 14. MOTHER S MAIDEN NAME burial, crematian, or remaval, 15 WAS DECEASED EVER IN U.S. ARMED FORCES? INFORMAN nderson 115-5, 574 ST. 16 SOCIAL SECURITY NO (Yes, no grunk nawn) (If yes give war ar dates of service) 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a)

CARDIAE INTERVAL BETWEEN signed by the burnal-transit p ONSET AND DEATH CARDIAC mornints Page 4 may be retained by the haspital ar attending physician. DUE TO YEART FAILURE Canditions, if any, which gave use to immediate couse (a). DUE TO stating the underlying cause of Health prior to has been as the PART IF OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY PERFORMED? U58 NO this certificate 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20g ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Hame, farm, 20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED (City or town) ((county) (State) Heur am. factory, street, affice bidg, etc.) Nat While at wark at work eceased fram Sep , 1966 to PRR 17, 1967, that (1) (we) last 67, and that death accurred at 1/3 M, fram causes and on the date stated above. 2]. I certify that (1) (this haspital) attended the deceased fram SPR director, page 3 shauld should be filed with the TO FUNERAL DIRECTOR: saw the deceased alive an APR 22b DATE SIGNED 22a SIGNATUR **ATTENDING** DIRECTOR 22d ADDRESS 22c. PHYSICIAN'S PORTER STNW 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 23b DATE THEREOF 23a BURIAL CREMATION. (County) Removal (Specify) Fisher Cemotery 4-19-1967 ADDRESS 24. FUNERAL DIRECTOR 25a REC'D BY REGISTRAR 2Sb REGISTRAR S SIGNATUR VR A15 (4) 25M 1/67 Sans Ingash DC

MARYLAND STATE DEPARTMENT OF HEALTH



10%21 Film 509 0-0-MARYWAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05358 05360 MEDICAL EXAMINER'S CERTIFICATE OF DEATH PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o COUNTY b (01/2 Page State Department af MARYLAND b CITY OR TOWN (If auts) re carparate I mit c LENGTH OF STAY N 1b c CITY OB JOWN (If outside carparate a mits, write RURAL and give nearest town) d STREET ADDRESS e IS RESIDENC (If not in haspita, give street address) farm ON A FARM be executed within 24 haurs after death. NAME OF Middle DATE Year DECEASED OF 27 Henson 8 GIVE (Type of print) 196 DEATH along 5 SEX IF UNDER 1 YEAR IF UNDER 24 HRS 6 COLOR OR RACE DATE OF BIRTH 9 AGE (In years 7 MARRIED NEVER MARR ED last birthday) Manths Davs Hours 5-3/-34 within 72 haurs after death WIDOWED DIVORCED Item] Office l and ? 12 CIT ZEN, OF WHAT 100 ESUAL OCCEPATION (Give k no of work done 106 KIND OF BES NESS OR 11 B RTHPLACE (State or fore gn, countr during most of work halife, even if retired) INDUSTRY ≘ Medical Examiner's pages pencil FATHER S NAME 14 MOTHER'S MAIDEN NAME 10 IS WAS DECEASED EVER NUS ARMED FORCES? 16 SOCIAL SECURITY NO INFORMAN permit. (Yes, no, ar unknown) (If yes give war ar dates of service es *ज/-*IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)." INTERVAL BETWEEN burial-transit event PART I DEATH WAS CAUSED BY ONSET AND DEATH Acute coronary insufficiency IMMEDIATE CAUSE (o) This certificate should the ward DUE TO any Conditions, fany, which gove Coronary artery heart disease (b) use to immediate cause (a). = DUE TO stoting the underlying cause Ď farwarded OS O last nsed 19 WAS ALTOPSY PERFORMED? remayal, PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINA. DISEASE CONDITION GIVEN IN PART (... CERTIFICATION NO certificate, YES be 20a. EXTERNAL CAUSE WAS 20b DESCR BE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 3 shauld shauld PRIMARY CONTRIBUTING CONTRIBUTING 5 CAUSE OF DEATH files crematian, MEDICAL 20d INJURY OCCURRED 20e PLACE OF NJERY (Hame farm 20f (City or town) 20c TIME OF INJERY Month, Day, Year (County) Haur om factory street, affice bldg etc.) While Not While may be retained far yaur FUNERAL DIRECTOR: Page at wark Inspection 🔀 21. I certify that Look charge of the remains described above, held an Autapsy X Inquiry X and in my apinian death resulted frames Natural causes 3 funeral directar. Acadent Sukide Hamicide Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASS STANT MEDICAL EXAMINER prior SIGNATURE O DEPUTY NAME (Type) / the 23d CBURIAL, CREMATION, 23b. DATE THEREO 0 REMOVAL (Specify) 24 FUNERAL 2Sb REGISTRAR'S SIGNATURE VR A15ME (5) 6M 1/67

DIVISION OF STATISTICAL RESEARCH AND RECORDS -CERTIFICATE OF DEATH PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admiss on) YINTY MARYLAND DN ODMERY TONTOOMERS death. b. CITY OR TOWN If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) SILVER d NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE OR INSTITUTION ON A FARM? YES NO Y *}OL* NAME OF Middle Last DATE DECEASED OF DEATH Pages deatht (Type or print) IF UNDER 1 YEAR IF UNDER 24 HRS 7. MARRIED NEVER MARRIED 9. AGE (In years last buthday) Months Days Hours WIDOWED | DIVORCED [100/ USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 13. BIRTHPLACE (State or foreign country) 12 CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME physici IS. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT 0 None attending CAUSE OF DEATH | Enter only one cause per line for (a), (b), and (c) INTERVAL BETWEEN PART I, DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) **DUE TO** Conditions, if any, which permit gave rise to immediate **DUE TO** couse (a), stating the underlying cause last. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) [19. WAS AUTOPSY PERFORMED? burial 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.] 20c. TIME OF INJURY Month. 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) Day, Year (County) (State) factory, street, affice bldg, etc.) Hour a. m While Not while of work of work p. m. 1967, that (1) (we) last 21. I certify that (1) (this ecspiral) attended the deceased fram. and that death occurred at 8 25 M. From the causes and an the date stated above saw the decleased alive an Match 15 , 1967 22a. SIGNATURE 22b, DATE ATTENDING THYS MED DIRECTOR TO FUNERAL DIRECTOR Page 3 shauld be G.M 22c PHYS CIAN'S 22d ADDRESS 23a BURIAL CREMATION. 23b DATE THEREOF NAME OF CEMETERY OR CREMATORY 23d LOCATION (City, town, or county) (State) 1967 Heaven Cemeteru 25b REGISTRAR'S SIGNATURE 250 REC'D BY REGISTRAR VR A15 (4) 15M 9/59



| 1 | MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND |
|---|--|
| FOR STATE | 35362 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05360 |
| HEALTH DEPT. | 1. PLACE OF DEATH a. COUNTY a. STATE b. COUNTY b. COUNTY |
| be be sth. | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MARYLAND C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) |
| cessary. e 5 may be Department after death. | DIEUN SPYING STILL TALKESTER |
| afte of the | d. NAME OF HOSPITAL OF INSTITUTION (I not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? |
| Page State | FOVEST Blankd 428/0Weller / de YES NOW |
| PM3. | NAME OF DECEASED (Type or print) Catherine O HINGOIS DATE Month Day Year OF DECEASED (Type or print) Catherine O HINGOIS DEATH DEATH 1987 |
| | 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. OATE OF BIRTH 9. AGE (In years I FUNDER 1 YEAR IF UNDER 24 HRS. Isst birthday) Months Days Hours Min. |
| 2 00 - 14 - 14 - 1 | WIDOWED DIVORCED 108. USUAL OCCUPATION (Give kind of work done 106. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT |
| 2 2 2 3 S | during most of working life, even if retired) AT Llane WASH, D.C. |
| rs after 18. Galong along ages 1 | 13. FATHER'S NAME |
| Item 1 Office a File pag and in | LOUIS L. COLLIE EMMA V. HATCHER 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address |
| it. F | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) (If yes give was or dates of service) 229-34-3694 MONTGOMERY E. H. 66INS-SAME AS # 2 |
| ted within in pencil in Examiner's sit permit. | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). A cut che and line to the lin |
| Exa Exa | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A BOSEVE COVO 22 VY / KVOTA TO DEATH |
| d be exect "pending" Medical burial-trar Cremation | Conditions, if any, which (b) |
| ld be "pe f Me buri crem | gave rise to immediata (cause (a), stating the DUE TO |
| ate should be word the Chief sed as a burial, | underlying cause lest.) (c) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY |
| incate the to the used r to bu | PERFORMED? YES NO NO |
| + 5 5 | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? PERFORMED? YES NO PRIMARY OF CONTRIBUTING CONTRIBUTING CAUSE WAS CAUSE OF DEATH. |
| R: This cer ate, writin forwarded 3 should t agent, prid | |
| incate to be to ge 3 ge 3 ed ag | 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hour a.m. While Not While at work At w |
| Para Est | 21. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion |
| EXA shou shou files Tork: design | death resulted from: Natural causes Accident , Suicide , Homicide , Undetermined manner CHIEF MEDICAL EXAMINER |
| HE SE SE SE | ACTUAL SIGNATURE ACSISTANT MEDICAL EXAMINER 22. DATE SIGNED |
| Y X Y Y | EXAMPRIER'S JOHN J. RODENS, MOC. DEPUTY MEDICAL EXAMINER D |
| D DEPUTY We please exertification. Pretained for Funeral of Health o | NAME (Type) 9 5 2 mg/h 2 / / / / Addres Street, city frown, or county) 23a. BURIAL, CREMATION, 23b. DATE THEREOF 1 23c. NAME OF CEMETERY DRUKEMATORY 1 23d. LOCATION (City, town or county) (State) |
| and designation of the second | BURIAL (Specify) 4/24/67 MT. COMFORT CEM. FLEXANDRIA, VA. |
| VR ALSME (5) | 124. FUNERAL DIRECTOR 5130 W.S. APPRESS W. 250. REGISTRAR 250. |
| 5AA 1/65 | BOS. CANLERS SONS, IN ASHINETON, D.C. BATENING O 1901 |

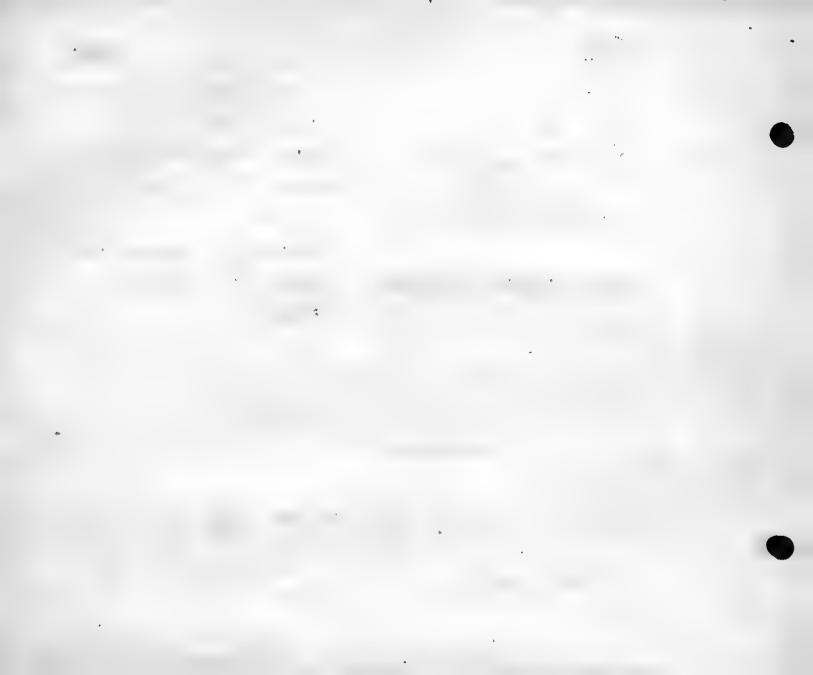


MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05363 MEDICAL EXAMINER'S CERTIFICATE OF DEATH PLACE OF DEATH 2 USUAL RESIDENCE (Where, deceased lived, if institution: Residence before admission) o. COUNTY o STATE EQUINTY MARYLAND C LENGTH OF STAY IN 12 c CITY OR TOWN (If gutside carposate limits, write RURAL and give nearest town) (If autside corporate I mits and wr to RUPAt and g ve podrest town P M3. 26-76-26 d. STREET ADDRESS e 15 RESIDENC d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) ON A FARM? 3 NAME OF Midale 4. DATE Doy Year DECEASED 6 COLOR OR RACE NEVER MARRIED DATE OF BIRTH lost, birthday) Manths Hours D-VORCED. event within 72 haurs after death. 12 C TIZEN OF WHAT 10a USUAL OCCUPATION (Give kind of work done 10b K ND OF BUSINESS OR during most of working life, every retired) 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Catherine Davis Sylvester Cole 17. INFORMANT 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. pending" in lef Medical E (Yes, no, or unknown) (If yes give wor or dotes of service John Hines-husband 1230 Queen St INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY Pulmonary Embolism. Mossive RALong farwarded to the Chief IMMEDIATE CAUSE (o) certificate, writing the ward DUE TO Thrombosis of Veins of Lett Leg any · cl 245 ? Conditions, if any, which gove rise to immediate couse (a). DUE TO stoting the underlying couse auna of Let teg. 6 WAS AUTOPS'
PERFORMED? PART IL. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) YES X 200 EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) PRIMARY OF CONTRIBUTING CAUSE OF DEATH Uf. Cus - and spring. Solt andle 70e PLACE OF INJURY (Hame, farm, (City or town) (County) (Stote) 20c TIME OF INJURY Month, Day, Year Not While W foctory, street, office b dq , etc) Woshington While DC Streat -Inspect on M. 21. I certify that I taok charge af the remains described above, held an Autapsy XI, Inquiry X and in my ap nian death resulted from Natural causes , Accident X, Suicide , Undetermined manner Hamicide CHIEF MEDICAL EXAMINER 22. DATE SIGNED ACTUAL ASSISTANT MEDICAL EXAMINER L SIGNATURE DEPUTY MEDICAL EXAMINER Health Address (Street, city, town, or county) NAME (Type) 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCAT ON (City of Town) 230 BURIAL CREMATION 0 REMOVAL(Specify) Lincoln Memorial Ceme. Marvland Burial VR A15ME (5) Stewart/Funeral Home-4001 Benning Rd., N. B. K.



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 95364 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY . CITY OR TOWN (If auts de Japarate limits, MARYLAND c. LENGTH OF STAY IN 16 write RURAL and give nearest town) ver Spring d. NAME OF HOSPITAL OR INSTITUTION (II) not in hospital, give street address) IS RESIDENCE ON A FARM? d. STREET ADDRESS YES IN NO IX NAME OF Middle First Day Year attending physician and campletely permit. Then please remave carlan DECEASED OF DEATH 196 (Type or print) IF JNDER I YEAR IF UNDER 24 HRS SEX 6. COLOR OR RACE X AGE (In years 7. MARRIED NEVER MARRIED last birthdoy) Days Hours DIVOR CED burial, crematian, or remayal, and in any WIDOWED 10a USJAL OCCJPATION (Give kind of work done 10b KIND OF BUSINESS OR 12 CITIZEN OF WHAT 11 BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired) COUNTRY? **INDUSTRY** DOMERIA 13 FATHERS NAME 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO (Yes, no, or unknown) (If yes give wor or dates of service) 18 CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c)) INTERVAL RETWEEN burial-transit ONSET AND DEATH PART I DEATH WAS CAUSED BYsigned by IMMEDIATE CAUSE (a) be retained by the haspital ar attending physician. DUE TO Conditions, if ony, which gove nse to immediate cause (b) DUE TO stating the underlying couse as the prior tak Page 4 may be retained by the haspital ar attending IO FUNERAL DIRECTOR: After this certificate has been PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) MEDICAL CERTIFICATION far use Health 20a. ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Post 1 or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) State Dept. 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Day, Year factory, street, affice bldg., etc.) Hour a.m. Not While 19 at work 21. I certify that (I) (this haspital), attended the deceased fram $\frac{y-16}{19}$, $\frac{19}{19}$, to $\frac{y-16}{19}$, $\frac{19}{19}$, that (I) (we) last saw the deceased alive an $\frac{y-16}{19}$, and that death accurred at $\frac{y-16}{19}$, fram causes and an the date stated above. 10. 19*2*, that (I) (we) last directar, page 3 shauld should be filed with the saw the deceased alive an DATE SIGNED 22n. SIGNATUR ATTENDING PHYS DIRECTOR M.D. 22d. ADDRESS George town 22c. PHYSICIAN'S NAME (Type) 23o. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) Bu REMOYAL (Specify) 4/21/67 Gate of Heaven Silver Spring, Md. 2Sb. REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR TYSON Wheeler Funeral Home-1331 Rockville Pike 2Sa. REC'D BY REGISTRAR VR A15 (4) 20 M 1/66 Rockville, Md.

MARYLAND STATE DEPARTMENT OF HEALTH



| | | | Division of STATIST | ICAL RESEA | ARCH AND RECORDS, 3 | 101 W. PRESTON S | FREET, BALTIMORE, MA | ARYLAND 21201 | |
|--|-----------------------|--|--|------------------------|---|--|---|-----------------------|--|
| | | 9536 | 5 | | CERTIFICAT | E OF DEATH | | 0536 | 3 |
| to get a get | | | ntgomery | | MARYLAND | o. STATE Mar | yland | COUNTY | set |
| ours af by the Page aurs af | | write RURAL one Bet | f outside corporate mits I give nearest tawn) thesda | | 37 days | | fautside corparate limits, wri ion Station | te RURAL and give ne | orest town) |
| led in 22 ho | 1 | | al or institution (if no | | ive street oddress) sda, Maryland | d STREET ADDRESS Box 199 | -E, Route 1 | | 9 IS RESIDENCE ON A FARM? YES NO KX |
| cecuted within 24 haurs after campletely filled in by the toye carban papers. Pages by eventually 172 haurs after the toyer carban papers. | 3 | NAME OF DECEASED Type or print) | Fir Dony | st | Middle Curtis | Holden | 4. DATE | Month pril | Day Year 7 19 67 |
| complete com | | Male | 6 COLOR OR RACE Negro | 7. MARRIED WIDOWED | NEVER MARRIED X | 8. date of Birth 12 January | 1950 9 AGE (In year last b other | ay) Months Da | |
| ertificate be exe physician and c hen please remo | 100 dur | USUAL OCCUPATION ng mast of working Stud | (Give kind of work done life, even if retired) ent | t0b. KI | ND OF BUSINESS OR DUSTRY None | 11. BIRTHPLACE (Con Mary | nty & State, or foreign country) Land | 12. CITIZEN COUNTI | OF WHAT RY? USA |
| physic physic hen ple noval, c | 13. | FATHER'S NAME | C. Holden | | | 14. MOTHER'S MAID | ila Handy | | |
| at the death cer the attending p isit permit. The mation, or remo | | WAS DECEASED EVE s, no, or unknown) No | R IN U.S. ARMED FORCES? (If yes give war ar dates a | i service) 21 | 2-56-1099 Th | INFORMANT The | Medical Recor Center, Beth | esda, Mary | |
| equires the physicion. sigmed by burial-trar burial, cre | | Conditions, if any, rise to immediat stating the under last. | e couse (a), DUE | (b) Pan | (0), (b), and (c)) ticemia cytopenia iculum Cell S | areome | | | interval between onset and peath 14. Days 5 Weeks 9 Months |
| Page 4 may be retained by the haspital or attending TO FUNERAL DIRECTOR: After this certificate has been directar, page 3 shauld be detached far use as the shauld be filed with the State Dept. af Health priar ta | ATION | PART II. OTHER SI | | | | | CONDITION GIVEN IN PART 1 | (a) | 19. WAS AUTOPSY PERFORMED? YES X NO |
| PHYSICIAN e haspital c his certificat stacked far Dept. af Hee | MEDICAL CERTIFICATION | (IF EITHER, NOTIFY | CAUSE OF DEATH MEDICAL EXAMINER) | | | | in Part I or Part II of Item 1 | <u> </u> | |
| DING PHYSIC by the haspi After this certi be detached State Dept. a | MEDIC | p. n | IRY Manth, Day, Year n. 19 | While at work | Not While of at work | LACE OF INJURY (Hame, actory, street, office bldg., | etc.) | | |
| OR ATTENDING De retained by the IIRECTOR: After e 3 shauld be ded with the State | | 21. I certification sow the decay signature | ty that (1) (this hospeceosed olive an | oitol) otteno April | ded the deceosed from. | 1 March not death accurred | ot 7:00 M, from col | Uses ond on the | , that CQ (we) los dote stated above |
| L OR A A DIRECT BORNECT SILED WITH INC. | | 22c. PHYSICIAN'S | Myps | n | Feain_ | M.D. ATTENDING PHYS. | MED. STAFF DIRECTOR PHYS. The Clinical | 🛛 8 Apr | il 1967 |
| O HOSPITAL OR Page 4 may be 10 FUNERAL DIRI director, page 3 shauld be filed v | 22- | NAME (Type) | Myroh J. | Levin | M.D. 23c. NAME OF CEMETERY C | Institu | tes of Health | , Bethesda | unty) (State) |
| TO HC Page TO FU direc | 230 | REMOVAL (Specify | 1 4/11/ | 6-7 | 2011 | NECO | MARUK | 1 S C D | md |
| VR A15 (4) | 2 | - Intent Diktery | 1/6 | and an | and Ill W | DATE DATE | P 1 1 1615 1967 25 | (Carles | sidge. |

MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 35366 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institut on: Residence before admission) o. COUNTY a. STATE b. COUNTY MARYLAND b CITY OR TOWN (If outside corporate limits, write RURAL and give-nearest town) c. LENGTH OF STAY IN 16 CCITYLOR, TOWN (If of tside corporate limits, write RURAL and give nearest town) IS RESIDENCE ON A FARM? d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give treet address) d STREET ADDRESS physician and completely wiled NO X NAME OF Middle 4. DATE corbon Last Year DECEASED OF DEATH 190 (Type or print) SEX DATE OF BIRTH 9. AGE (In years FUNDER 1 YEAR I IF UNDER 24 HRS & TOLOR UK 7, MARRIED NEVER MARRIED please remove last birthday) Davs Hours WIDOWED DIVORCED / 12. CITIZEN OF WHAT 1Db KIND OF BUSINESS OR 11 BIRTHPLACE (County & State or foreign country) COUNTRY? during most of warking life, even if refired) INDUSTRY 13. FATHER S NAME 14 MOTHER 5 MAIDEN NAME Min5/00 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) (If yes give wor or dates of service) 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) INTERVAL BETWEEN burial-tronsit p ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) signed by DUE TO Conditions, if any, which gove rise to immediate couse (o), DUE TO stoting the underlying couse as the prior to TO FUNERAL DIRECTOR: After this certificate has been lost (c) WAS AUTOPS PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) PERFORMED? detached for use te Dept. of Health YES [NO 200. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port II of item 18.) (IF EITHER NOTIFY MEDICAL EXAMINER) 2Dd INJURY OCCURRED 2De. PLACE OF INJURY (Hame, form, (City or town) (County) (State) 20c. TIME OF INJURY Manth, Day, Year Hour o.m. foctory, street, office bldg., etc.) Not While 21. I certify that (I) (this haspital) attended the deceased fram. , that (I) (we) last should director, page 3 should should be filed with the 19/2 saw the deceased alive an, and that death occurred at M, fram causes and an the date stated above 22o. SIGNATURE 22b. DATE SIGNED **ATTENDING** M.D. PHYS DIRECTOR PHYS. 22d ADDRESS 22c. PHYSICIAN'S NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 230, BURIAL, CREMATION, 23b DATE THEREO (County) (State) REMOVAL (Specify) SANdy 2Sa. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE JUNERAL DIRECTOR

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| (L. | Division of STATISTICA | MARYLAND STATE DE L RESEARCH AND RECORDS, 30 | PARTMENT OF HEALTH I W PRESTON STREET RA | ITIMORE MARYLAND 21201 | |
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| | 95 367 | | OF DEATH | and the same of th | |
| (₩ FZ= | | CENTITIONS | | 15855 | _ |
| dea | 1. PLACE OF DEATH o (OUNTY / | | 2 USUAL RESIDENCE (Where de | b. COUNTY | , |
| free for a litter of the free for a little of | b. CITY OR TOWN Alf outside corporate limits, | MARYLAND c length of stay in 16 | | porate limits, write RURAL and give nearest town) | _ |
| ours after death | write RJRAL and give nearest town) | 1-1. | wheaten | The d | |
| hou hou | d. NAME OF HOSPITAL OR INSTITUTION (IF not in I | hospitol, give street address) | d. STREET ADDRESS | e IS RESIDENC ON A FARM | Ē |
| in 24 hours after death filled in by the funeral papers. Pages 1 and 2 hin 72 hours after death | Holy COASE HO | coltal | Valiversit | ON A FARMS | |
| opd completely filled in remove corban papers. | 3 NAME OF First | Middle , | Losi 4. DA | E Month Doy Year | = |
| d with detely carban int, with | (Type or print) MAMIE | To Ho | Maway OF | TH X 9 19 6 | 7 |
| integral integral | S. SEX 6. COLOR OR RACE 7. I | MARRIED NEVER MARRIED | 8 DATE OF BIRTH | 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 In lost birthdoy) Months Doys Hours N | HRS. fin. |
| execut remove | 16410 | IDOWED DIVORCED | 12/2/1890 | 7 6 yes. | |
| 2 8 2 | 100. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, of | or foreign country) 12 CITIZEN OF WHAT COUNTRY? | |
| ate icion | 14005ECU1FE | | 14 MOTHER'S MAIDEN NAME | AROLINA W. J.H | |
| physen powal | | TATE | EMMA | 2 | |
| ing h ce | 1S WAS DECEASED EVER IN U.S. ARMED FORCES? | 16 SOCIAL SECURITY NO 17. I | INFORMANT | Address | _ |
| attendir permit. ion, or re | (Yes, no, or unknown) (If yes give wor or dotes of sen | rice) | INIANT. (66 | -65 6717-13 PLACEN. | w |
| PHYSICIAN: The low requires that the death certificate be executed within 24 hours after the hospital or attending physician. This certificate has been signed by the attending physician and completely filled in by the fustoched for use as the buriol-transit permit. Then please remove carbon papers. Pages 1 Dept. of Health prior to buriol, cremation, or removal, and interpretation, within 72 hours after the properties of the prior to buriol. | 18 CAUSE OF DEATH (Enter only one couse pe | r line for (o) (b), and (c).) | 6/! | ONSET AND DEATH | N . |
| hot n. vy # onsi | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) | Mente Culour | racy (Alma | I CAR . and all deals | 4 |
| ed the ol-tr | Conditions, if ony, which gove) (b) | artinosolo, o | White and In | K. Dine Du | |
| Phy sign Wari | rise to immediate couse (a), | And a | . Cargiocus como | Wiedard mounty | |
| t: The low re or aftending te has been use as the alth prior to | stoting the underlying couse (c) | (Eld age. | | | |
| e lo trenctant de la priore priore la priore l | PART II. OTHER SIGNJEICANT CONDITIONS CONTR | IBUTING TO DEATH BU NOT RELATED TO | THE TERMINAL DISEASE CONDITION (| GIVEN IN PART 1(o) 19 WAS AUTOPSY PERFORMED? | |
| PHYSICIAN: The low re the hospital or attending this certificate has been etoched for use as the cooked, of Health prior to | 200. ACCIDENT WAS UNDERLYING TO OR CONTRIBUTING THE ARMS OF DEATH OF THE PROPERTY OF THE ARMS OF THE A | my Disease | | YES NO | L |
| JCIAN pital riffico d for of He | 200. ACCIDENT WAS UNDERLYING I | 205 DESCRIBE HOW INJURY OCCURRED | (Enter noture of injury in Part I or | Port II of item 18) | |
| PHYSICIAN he hospital this certifica etoched for | | Tool hillery occurred. | CE OF INJURY (Home, form, 20 | f. (City or lown) (County) (State | |
| | 20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. 19 | 20d. INJURY OCCURRED While Not While of work | ory street, affice bldg , etc.) | i. telly of lowilly (cooling) (store | 7 |
| Mffer Stots | 21. 1 certify that (I) (this haspita | of work — of work — | Car. 7 191. 7 | 1 to are 2 9 , 196 / that (1) (we) | la |
| ned ned the the | | 1967, and tha | t death accurred of 5 | M, from causes and an the date stated ob | |
| OR ATTENIOR DIRECTOR: A Should be a 3 should sed with the | 220. SIGNATURE | / | ATTENDING MED. | STAFF 22b. DATE SIGNED | |
| DIRE 3 | 1 Amfoline | M. | D. PHYS DIRECTO | R PHYS. 10,196 | _ |
| PITAL O may be ERAL DIR ir, poge | NAME (Type) Ka Bufa | - (INO M. D) | 1429 Uhrere | city Blood of Selvy low | , صرار |
| TO HOSPITAL OR ATTENDING Poge 4 may be retained by the TO FUNERAL DIRECTOR: After a director, page 3 should be d should be filed with the Stote | 230 BURIAL, CREMATION, 23b. DATE THEREON | | | LOCATION (City or Town) (County) (Stote | ,, 0 |
| Pog Pog Short Short | REMOVAL (Specify) 6 4-12-19 | 967 VIOLET | | shville N. (d) | 4 |
| | 24. FUNERAL DIRECTOR Ky R. Ris. | hes ADDRESS | 2So. REC'D BY REG | COTTAL AND A CARACTERIA | |
| VIII A15 (4) 20 M 1/66 | IN. EDNEST NARVI | 1 40, 1432 Year | STA SMAPR 1 | 3 1967 June 1967 | |



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 95368 CERTIFICATE OF DEATH 05366 **OR ATTENDING PHYSICIAN:** The low requires that the death certificate be executed within 24 haurs ofter death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. COUNTY Montgomery b. COUNTY Pennsylvania MARYLAND b CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn)
Bethesda c CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 100 days New Enterprise d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e IS RESIDENCE ON A FARM? R.D. # The Clinical Center, Bethesda, Md. 20014 NO EX YES 3. NAME OF DECEASED 4. DATE Day Year OF DEATH Aileen event, (Type ar print) Chery] Holt 19 67 IF UNDER 1 YEAR IF UNDER 24 HRS AGE (In years S SEX 6. COLOR OR RACE B DATE OF BIRTH 7 MARRIED NEVER MARRIED last birthday) Hours Female White WIDOWED DIVORCED 6 October 1945 10a. USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State or fareign country) 12. CITIZEN OF WHAT U.S.A. during mast of working life, even if retired) INDUSTRY Pennsylvania 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Kenneth P. Holt cremation, or remov Helen Cogan 17. INFORMANT The Medical Records IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. (Yes, no, ar unknown) (If yes give war or dates of service) Not available The Clinical Center, Bethesda, Maryland 2001 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) NTERVAL BETWEEN signed by the burial-transit buriol, cremati ONSET AND DEATH PART I. DEATH WAS CAUSED BY Respiratory insufficiency IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gave unknown Bronchiectasis rise ta immediate cause (a). DUE TO stating the underlying cause this certificate has been detached for use as the since birt Cystic fibrosis 19 WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(g) YES X NO 20b, DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18) 200 ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL (City or town) (State) 20c TIME OF INJURY Manth, Day, Year 2Dd INJURY OCCURRED 2De PLACE OF INJURY (Home, form, (County) factory, street, affice bldg., etc.) Hour a.m. Not While 21. I certify that (1) (this haspital) attended the deseased from Jan. 11 , 1967, to April 21, 1967, that (1) (we) las 19/67, and that death accurred at 10:45M, from causes and on the date stated above saw the deceased alive an April TO FUNERAL DIRECTOR: 22a. SIGNATURE 22b. DATE SIGNED ATTENDING X April 22, 1967 DIRECTOR PHYS. 22d ADDRESS The Clinical Center National 22c. PHYSICIAN S NAME (Type) David N. Soghor Institutes of Health Bethesda Md 20014 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23g BURIAL, CREMATION (County) REMOVAL (Specify) Frandview Cemetery altonna, ronn grvonia Puneral Home-1351 25a REC D BY REGISTRAR 25h REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR healer ochville I



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05369 CERTIFICATE OF DEATH filled in by the funeral n papers. Pages 1 and 1 ithin 72 haurs after death requires that the death certificate be executed within 24 haurs after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o. COUNTY o. STATE b. COUNTY Montgomery Virginia MARYLAND b. CITY OR TOWN (f outside corporate limits. c LENGTH OF STAY IN 16 c CITY OR TOWN (If gutside corporate limits, write RURAL and give nearest town) write RLRAL and give nearest town)
Bethesda (rural 22 days Woodbridge d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e IS RESIDENCE ON A FARM? event, within 72 Naval Hospital 903 Essex Drive YES NO TO Middle 3 NAME OF First 4 DATE Month Doy Year DECEASED (Type or print) Vaughn HOLT JF UNDER 1 YEAR Erland April DEATH S SEX 6 COLOR OR RACE B DATE OF BIRTH 1927 9 AGF (In years IF UNDER 24 HRS 7. MARRIED KX **NEVER MARRIED** lost birthdoy) Months Doys Hours signed by the attending physician and ca burial-transit permit. Then please remav burial, crematian, or removal, and in any a WIDOWED DIVORCED December 11. Male Cauc 10o USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11 BIRTHPLACE (County & State or foreign country) 12 CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) INDUSTRY Towa 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Jess Holt Sarah Martin IS WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT Woodbridge Address Virginia 16. SOCIAL SECURITY NO. Yes, no, or unknown) (If yes give wor or dates of service) 24 2001 Mrs. Gladys Holt, 903 Essex Drive 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN ONSET AND DEATH HODGKINS DISEASE IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate couse (a). DUE TO stating the underlying cause the (r) 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) CERTIFICATION YES X NO F TO FUNERAL DIRECTOR: After this certificate director, page 3 shauld be detached far us shauld be filed with the State Dept. af Healt 20o ACCIDENT WAS UNDERLYING [205, DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 3B.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER (City or town) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (County) (Stote) foctory, street, office bldg. etc 1 Not While at work ot wark 21. I certify that (this haspital) attended the deceased from Apr. 6 ____, 19_67_ ta_Apr__.27_, 1967_, that 1t) (we) last 19 67, and that death occurred at 132M, from couses and on the date stated above. saw the deceased alive an Apr. 27 22a. SIGNATURE 22b DATE SIGNED APRIL 29,1967 UNINN M.D. PHYS. DIRECTOR PHYS. 22c. PHYSICIAN'S Naval Hospital, Bethesda, Md. NAME (Type) R.J.KINNEY 230 BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) 5-2-67 Arlington National Arlington Virginia Buria 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURI 24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home VR A15 (4) 20 M 1/66 Museles 7557 Wisconsin Ave., Bethesda, Maryland



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, functifution, Residence before admission) o STAVirginia COUNTY Montgomery ofter death. MARYLAND b. CITY OR TOWN (If outside corporate limits, r LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) D.O.A. Falls Church d NAME OF HOSPITAL OR INSTITUT ON (If not in hospital, give street address) d STREET ADDRESS S RESIDENCE ON A FARM? Holy Cross Hospital 123 South Lee Street NO. 3 NAME OF First Middle 4. DATE Lost Month DECEASED Frederick April 7, 1967 Emil Holtz (Type or pant) DEATH S. SEX IF UNDER 1 YEAR IF UNDER 24 HRS 6 COLOR OR RACE B DATE OF BIRTH AGE (In years 7 MARRIED NEVER MARRIED lost berthday) Hours December 4, 1930 White Male WIDOWED DIVORCED 1Do USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11 BIRTHPLACE (State or foreign country) 12 CITIZEN OF WHAT during most of working life, even fretired) INDUSTRY COUNTRY? Pittsburg, Penna. In any IXAGOGGE Home construction 14. MOTHER'S MAIDEN NAME 13 FATHER'S NAME Emil E. Holtz Sarah Kina 17 INFORMANT 16 SOCIAL SECURITY NO Add 008 Chartiers Ave. ar remayal, Beglinger Funeral Home Pittsburg INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o) (b), ond (c)) ONSET AND DEATH PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) word crematian, Conditions if any, which gave rise to immediate couse (a), DUF TO storing the underlying couse 0 WAS AUTOP PART II OTHER SIGNIFICANT CONDITIONS CONTRIBLTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMED? 2Do EXTERNAL CAUSE WAS PRIMARY DE OF CONTRIBUTING ☐ CAUSE OF DEATH. HOW INJURY OCCURRED (Enter/hotuse of injury in Paul I OF INJURY (Home, farm, of work and in my opinion 2). I certify that I taok charge of the remains described above, held an Autopsy Inspection X death resulted from. Notural causes Accident X Suicide Undétermined monner ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE, the funeral **EXAMINER'S** 5 may 10 FUNE Health 23c NAME OF LEMETRY OR CREMATORY MEWOOD 23b DATE THEREOF 23d LOCATION (Coff or Town) 23o BURIAL CREMATION Pittsburg. VR A15ME (5) 6M 1/66 Silver Spring



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05371 CERTIFICATE OF DEATH 24 hours after death funerol and pup PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution, Residen 9 a. COUNTY b. COUNTY Montgomery MARYLAND Montgomery Pages the b CITY OR TOWN (If autside carparate imits, write RURAL and give nearest town) c. CITY OR TOWN (If autside carparate limits, write RURAL and give negrest town) c LENGTH OF STAY IN 16 Ednor rely filled in I d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? Hospital Montgomery Gemeral NO YES PHYSICIAN: The law requires that the death certificate be executed within NAME OF Middle 4. DATE Manth Day Year DECEASED William Arthur o od 26 April ő (Type or print) DEATH and in ony event, IF UNDER 1 YEAR IF UNDER 24 HRS S. SEX 6 COLOR OR RACE DATE OF BIRTH 9. AGE (In years 7. MARRIED NEVER MARRIED remove last birthday) Manths Hours 1-18-98 lale Negro WIDOWED DIVORCED pup 10a. USUAL OCCUPATION (Give kind of work dane 10b. KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CIT ZEN OF WHAT physician a COUNTRYTISA during most of working Life, even if retired) INDUSTRY Harvland 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME cremotion, or remayal, attending phys Charles R. Hood Martha Fuller 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, ar unknawn) (If yes give war ar dates af service) 16. SOCIAL SECURITY NO 17. INFORMANT Address permit. INTERVAL BETWEEN ONET AND DEATH 18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c) signed by the burial-transit PART I. DEATH WAS CAUSED BY Lunbolism Wirnowson IMMEDIATE CAUSE (a) Page 4 may be retained by the hospital or attending physician. DUE TO Candit ans, if any, which gave rise to immediate cause (a). DUE TO stating the underlying cause has been the be detached for use as the State Dept. of Health prior to YCELYS WAS AUTOPSY PERFORMED? OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT Ebhioselevosis NO A **DIRECTOR:** After this certificate 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20a ACCIDENT WAS UNDERLYING ET OR CONTRIBUTING CAUSE OF DEATH detoched (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e, PLACE OF INJURY (Hame, Farm, TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED (State) (County) 2 Hour am. factory, street, affice bldg, etc.) Nat While at wark at work certify that (I) (this haspital) attended the deceased from Jun that (I) (we) last , page 3 should be filed with the and that death accurred at 3:40 mfrom causes and on the date stated above. sow the deceased alive on 22c SIGNATURE 22b DIRECTOR 22d. ADDRESS 10 FUNERAL OLNEY, MARYLAND NAME (Type) RICHARD A. YATES. director, g 23c NAME OF CEMETERY OR CREMATORY 23a BURIAL, CREMAT ON 23b DATE THEREOF 23d LOCATION (City or Town) (State) (County) Spring Cem. Sandy Sandy REC D BY REGISTRAR 24. FUNERAL DIRECTOR **ADDRESS** 1967 VR A15 (III) Robert L. Snowden Rockville. Md 25M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05372 CERTIFICATE OF DEATH O The law requires that the death certificate be executed within 24 haurs after death in by the funeral ers. Pages I and 2 2 hours after death death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY o. STATE MARYLAND **b** COUNTY MONTGOMERY MARYLAND MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c LENGTH OF STAY IN 16 c CITY OR FOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA BETHESDA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS IS RES DENCE ON A FARM? .⊑ filled 5600 SPRINGFIELD DRIVE NO K 5600 SPRINGFIELD DRIVE YES completely fi nove carbon Middle NAME OF First DATE Doy Year 3 DECEASED 0F MARIE HOPKINS ANNA a 19 6 (Type or pnnt) DEATH IF UNDER 1 YEAR IF UNDER 24 HR 6. COLOR OR RACE 7. MARRIED NEVER MARRIED DATE OF BIRTH AGE remove lost birthdoy) Months Doys Hours WIDOWED DIVORCED and in any MARCH 2.1902 ond 100 USUAL OCCUPATION (Give kind of work done 11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT 106 KIND OF BUSINESS during most of working life, evenif retired) COUNTRY? physician (nen pleose EINDUSTRY IRELAND Housewitc 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME or removal, AUSTIN CLANCY SR. MARY HAYES Address a, Md. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO (Yes, no, or unknown) (ill yes give wor or dates of service Dr. Gerald A. Hopkins 5600 Springfield Dr. NOcremation, INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (t).)
PART I. DEATH WAS CAUSED BY. ONSET AND DEATH burial-tronsit signed by IMMEDIATE CAUSE (o) DUE TO buriol Conditions, if any, which gave (b) rise to immediate couse (a). DUE TO stoling the underlying couse os the prior to by the hospital or attending lost. WAS ALTOPS PART H. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(d) nas PERFORMED? Heolth | NO D this certificate OR ATTENDING PHYSICIAN: 200 ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 18) OR CONTR BLTING CAUSE OF DEATH detoched (IF EITHER, NOTIFY MEDICAL EXAMINER) Stote Dept. MEDICAL 20c. TIME OF INJURY Month, Dov. Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or lown) (Stote) Heur o.m. foctory, street, office bldg., etc.) Not While of work 21. 1 certify that (1) (this hospital) attended the deceased from 1 be retained 0 saw the deceased alive an A and that death accurred at 4. A. M. fram shuses and an the date stated abave. O FUNERAL DIRECTOR: 22o. SIGNATURE DATE SIGNED director, page 3 should be filed v DIRECTOR PHYS 22d **ADDRESS** 22c. PHYSICIAN'S NAME (Type) NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) BUR.A., CREMATION DATE THEREOF (Ytruo)) 4/24/67 Gate of Heaven Cemetery SilversPring Wontgomery
ADDRESS 250 REC'D BY REGISTRAR 7 255. REGISTRAR'S SIGNAFORE 24. FUNERAL DIRECTOR Wash.D.C. VR A15 (4) 25M 1/67 Joseph Gawler's Sons 5130 Wisc. Ave.N.W.



| 1 | MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND |
|---|--|
| A Ava ta | 05373 CERTIFICATE OF DEATH 05371 |
| 24 hours after death. Filled in by the funeral apers. Pages 1 and 2 and 72 hours after death. | 1. PLACE OF DEATH a COUNTY PION COUNTY MARYLAND 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before adminsion) a. STATE b. COUNTY |
| ours affi in by th Pages nours af | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. |
| | d. NAME OF HOSPITAL DR INSTITUTION (if not in hospital, give street address) Carroll Hall Sanitarium 10231 Carroll Place d. STREET ADDRESS 4133 New Hampshire Ave. N. ON A FARM? YES NO |
| d within | 3. NAME OF FIRST Middle Last 4. DATE Month Day Year OF (Type or print) WILLIAM Frank HORTMAN DEATH APRIL 18 1967 |
| executed within 24 hours af and completely filled in by the remove carbon papers. Page many event, within 72 hours and | 5. SEX 6. CDLOR DR RACE 7. MARRIED NEVER MARRIED 8. DATE DF BIRTH last birthday) 8. AGE (In years FUNDER 14EAR FUNDER 24 HRS. Months Days Hours Min. Months Days Hours Min. Months Days Hours Min. Min |
| physician physician n please | 10a. USUAL DCCUPATION (Give kind of work done 10b. KIND DF BUSINESS DR durps most of work legistration of work legistration of the library of |
| certifica iding ph Then removal | Stewart Hortman Louella Metz . |
| eath ce attend ermit. on, or re | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) (If yes give war or dates of service) 578-52-4235 Nellie I. Hortman same as #2 |
| FITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 may be retained by the hospital or attending physician. FRAL DIRECTOR: After this certificate has been signed by the attending physician and completely jor, page 3 should be detached for use as the burial-transit permit. Then please remove carbon is be filed with the State Dept. of Health prior to burial, cremation, or removal, uncommany event, with | 18. CAUSE OF DEATH LENter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. DTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II. 20a. ACCIDENT WAS UNDERLYING TO DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20b. TIME DF INJURY Month, Day, Year While at work Now while at work 19 and that death occurred at 19 at work 19 and that death occurred at 19 at 10 per |
| TO HOSPITAL OR Page 4 may be TO FUNERAL DIRE director, page 3 should be filed v | NAME (Type) Henry M. Lowden 23a. BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY DR CREMATORY 23d. LOCATION (City, town or county) burial 4/20/67 Glenwood Cemetery Washington, D.C. 24. FUNERAL DIRECTOR. 25b. REGISTRAR'S SIGNATURE |
| VR A15 (4) 15M 4-64 | 24. FUNERAL DIRECTOR. H. Hines Co. 2901 14th St. N. DATE APR 20 1967 Clearles Judge. |

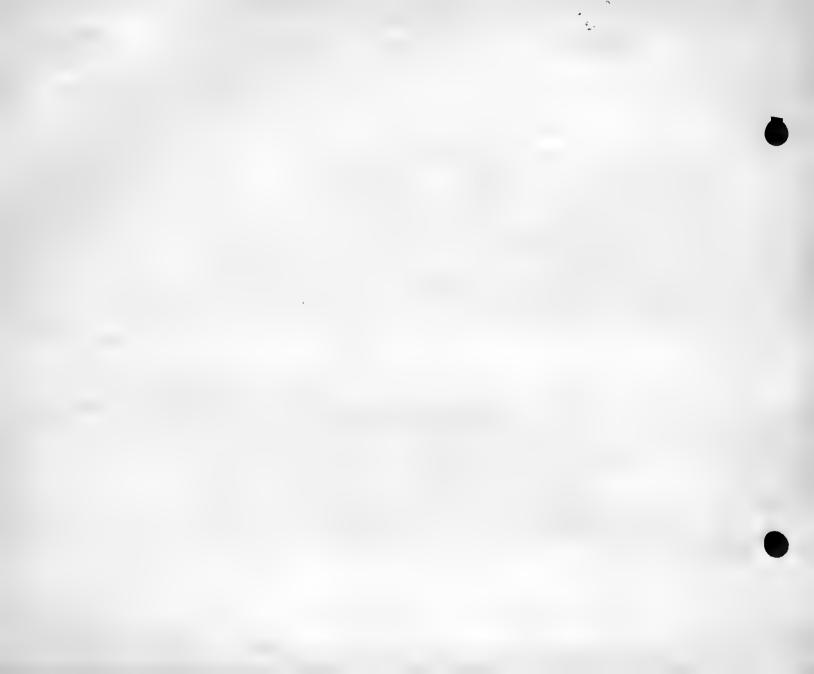


MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

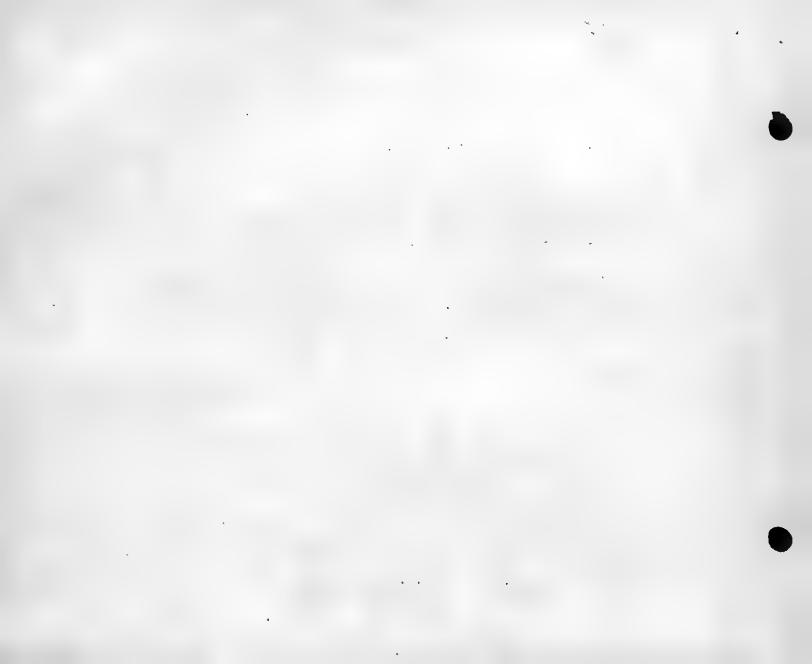
| | 05374 | CERTIFICATE | OF DEATH | | 05372 |
|----------------------|---|--|---|-----------------------------|---|
| ٦. | PLACE OF DEATH | | 2. USUAL RESIDENCE (Where | | |
| | o. COUNTY Mondayme | Z. MARYLAND | a. STATE Marcel | b. COUNTY | Mondaymens |
| | b. CITY OR TOWN (f outside exparate limits, write RURAL and sixe newsest town) | C. LENGTH OF STAY IN 16 | c. CITY OR TOWN (If ends de c | arparate limits, write RURA | L and give neatest town) |
| | Wille ROKAL UIII ALGE HEURS, JOWN) | 6- Kes. | Ken | singlen | 1-1 |
| Ī | d NAME OF HOSPITAL OR INSTITUTION (IF not in | | d STREET ADDRESS | , 0 | e IS RESIDENCE ON A FARM? |
| | Dulius | | 4005 PK | ylio mill. | ed YES NO. 1 |
| | NAME OF First | Middle | | ATE Month | Doy Year |
| | (Type or print) Telburs | | | DEATH Opri | - 1/4/ |
| > | ~ 0 | THE RESERVED IN | 8 DATE OF BIRTH | | IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min |
| _ | 771 | WIDOWED DIVORCED | 0/30/86 | 80 yrs. | 12 CITIZEN OF WHAT |
| U | o. USUAL OCCUPATION (Give kind of work done ring most of working life, even it retired) | 106. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State | , or foreign country) | COUNTRY 7 |
| | B. FATHER'S NAME | | 14 MOTHER'S MADEN NAME | na | 12121 |
| 1 % | midtan 16 | . Han I | 1 1,660 | 2 | |
| 14 | WAS DECEASED EVER IN J. S. ARMED FORCES? | 16 SOCIAL SECURITY NO. 17 | INFORMANT/ | Address | 11,005 - |
| | es, na, or unknown) (If yes give war ar dates af se | | =/11/0 / | 111/201 | 15-2-len 11 /2 |
| = | 18 CAUSE OF DEATH (Enter only one couse | ner the for (a) (b) and (c)) | 1/0/60 | 111 | INTERVAL BETWEEN |
| | PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | A. T. MYDIAG | DIAL INFAR | CTION | ONSET AND DEATH |
| | 4 20 / DUE TO | | | | |
| | Canditions, if any, which gave) (b) | CORONARY ATH | ERUSCLE ROS | IS | UNKNOWNY |
| | rise to immediate couse (o), DUE TO | | | | |
| | lost. (c) | | | · | |
| × | PART II OTHER SIGNIFICANT CONDITIONS CONT | | THE TERMINAL DISEASE CONDIT OF | GIVEN IN PART 1(a) | 19 WAS AUTOPSY PERFORMED? |
| FICALION FICALION | | NOME | | | YES MO |
| 7 | 20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 20b DESCRIBE HOW INJURY OCCURRED | (Enter nature of injury in Part I | or Part II of item 18) | |
| A S | (IF EITHER, NOTIFY MEDICAL EXAMINER) | Leaf hybrid factions | de ag nomen (i) | 20/ 15 | 16 |
| | 20c TiME OF INJURY Month, Day, Year Haur o.m. | 20d. INJURY OCCURRED 20e, PLA While Not While fact | CE OF INJURY (Home, farm, ary, street, affice bldg, etc.) | 20f (City or town) | (County) (State) |
| | β.m. 17 | atwork LJ atwark LJ | | 1 . A. Star 7/ | 10/ 2 1 10 (2.2) |
| | sow the deceased alive on A.F. | al) ottended the deceased from | t death accurred at 131. | A M from rauses or | ind on the date stated obove |
| | 220 SIGNATURE | 7, 510 110 | deam accorded and | Z_M, Hom cooses of | 22b. DATE SIGNED |
| | E. A. male. 1 | Tocara and MI | ATTENDING MED. PHYS DIRECT | TOR PHYS | APRIL 29, 967 |
| | 22c PHYSICIAN'S | 4 8 | 22d ADDRESS / C/ S | SPRING : | 37, |
| | NAME (Type) EDLUARD | A. BEEMAN | 512 | ER SPRIYE | . MJ |
| 23 | d. BURIAL, CREMATION 23b. DATE THERE | OF 23c NAME OF CEMETERY OR | CREMATORY - 23 | OCATION (City of Town | (Caunty) (State) |
| | Durial May 3 | 1967 ash me | marial & | early sp | unes Monta Mis |
| 1 | 4 EUNERAL DIRECTOR | ADDRESS Quel | Recella 250 REC'D BY R | EGISTRAR 256 REGI | STRAR'S STGNATURE |
| | Kallell dism | muden, the | med DATMAY 5 | 1904 | 0 1 |

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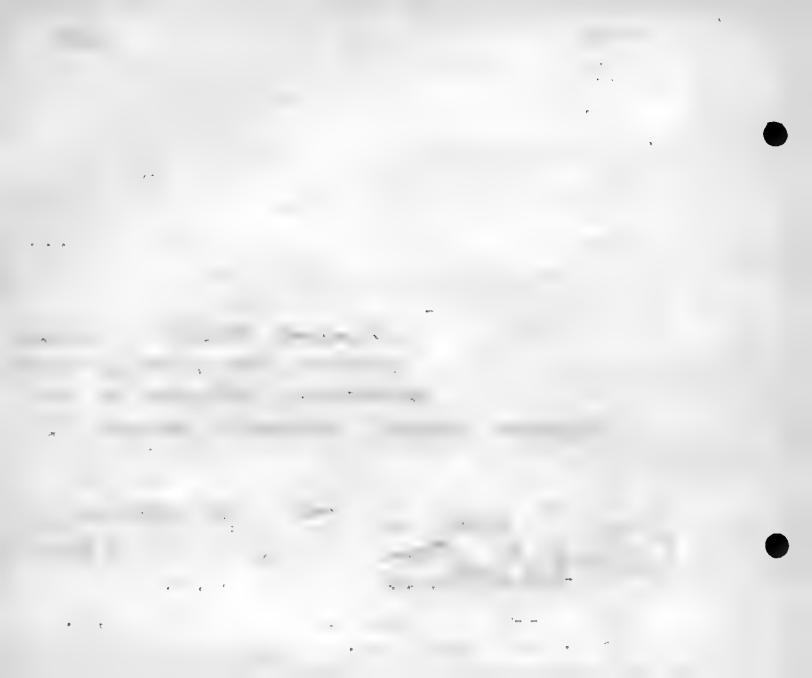
to Hospital or attending PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. Page 4 may be retained by the hospital ar attending physician.



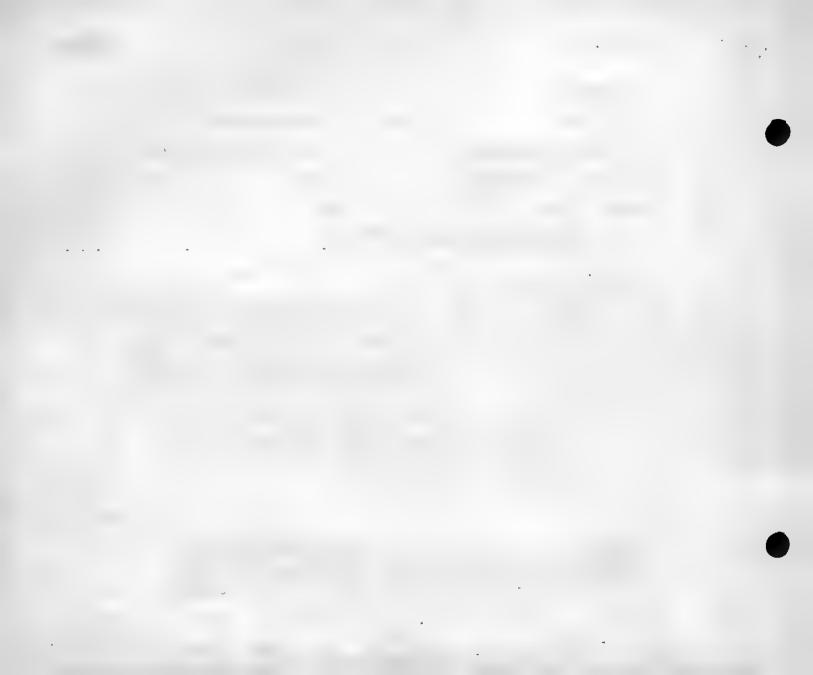
| <u>, 1.</u> | MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 |
|--|--|
| | 05375 CERTIFICATE OF DEATH 05373 |
| thin 24 haurs after death. filled in by the funeral in papers. Pages I and ithin 72 haurs after death. | PLACE OF DEATH o. COUNTY MONT COMETY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND MARYLAND C. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) C. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) |
| 24 haurs of d in by the pers. Page 72 haurs | d NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? |
| be executed within 2 and campletely fuller temaye carban par in any event, within | The Clinical Center, Bethesda, Maryland 13313 Wye Oak Drive, Route 3 YES NO NO NAME OF DECEASED (Type or print) William Charles Howarth DEATH April 5 19 67 S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B DATE OF BIRTH 9. AGE (In yeors FUNDER 1 YEAR FUNDER 241) |
| s be execut an and cam ise remaye | S. SEX 6. COLOR OR RACE Male Mite Midowed Divorced Divorced January 3, 1931 January 3, 1931 New York Full ding Contractor Self employed New York AGE (In yeors lost lift UNDER 1 YEAR IF UNDER 1 YE |
| h certificate ing physicic Then plea emoval, an | 13. FATHER'S NAME Earl R. Howarth Agnes Grant 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT TO A Address. |
| equires that the death certificate be exec physician. signed by the attending physician and ca burial-transit permit Then please rema burial, crematian, ar removal, and in any | (Yes, no, or unknown) (If yes give war or dotes of service) Yes 1948-1952 Not available The Clinical Center, Bethesda, Maryland 18. CAUSE OF DEATH (Inter only one couse per line for (o), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Intracerebral Hemorrhage 222 Nous Andrews A |
| O HOSPITAL OR ATTENDING PHYSICIAN: III law requires that the death certificate be executed within 24 haurs after death. Page 4 may be retained by the haspital or attending physician. O FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the funeral director, page 3 should be detached far use as the burial-transit permit. Then please remaye carban papers. Pages I and should be filed with the State Dept. af Health priar ta burial, crematian, ar removal, and in any event, within 72 haurs after death. | Canditions, if any, which gove rise to immediate cause (o), storting the underlying couse (o) (c) DUE TO (b) Acute Myelogenous Leukemia 4 weeks DUE TO (c) |
| N: TT= for or atten or atten ate has bar use as eath price | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES \(\overline{\o |
| HYSICIA haspital is certific ached fa ept. af H | 20c, TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (State |
| ADING P d by the Affer th d be det d be det | 21. I certify that XIX (this haspital) attended the deceased from April 1, 1967, ta April 5, 1967, that (IX (we) |
| TO HOSPITAL OR ATTENDING PHYSICIAN: The law re Page 4 may be retained by the haspital or attending TO FUNERAL DIRECTOR: After this certificate has been director, page 3 should be detached far use as the should be filed with the State Dept. af Health priar to | 220. SIGNATURE ATTENDING MED. STAFF 22b. DATE SIGNED |
| HOSPITA age 4 may FUNERAL director, po | NAME (Type Jerry L. Spivak, M.D. Institutes of Health, Bethesda, Maryla 230. BURIA, (REMATION, 88MOVAL (Section) 231. DATE THEREOF 232. NAME OF CEMETERY OR CREMATORY 233. LOCATION (City or Town) (County) (Stole) |
| VR A15 (4) \ 20 M 1/66 | 24, HINERAL DIRECTOR Funeral Home-1331 Rockville Pike Rockville Md. Rockville Md. Rockville Md. |



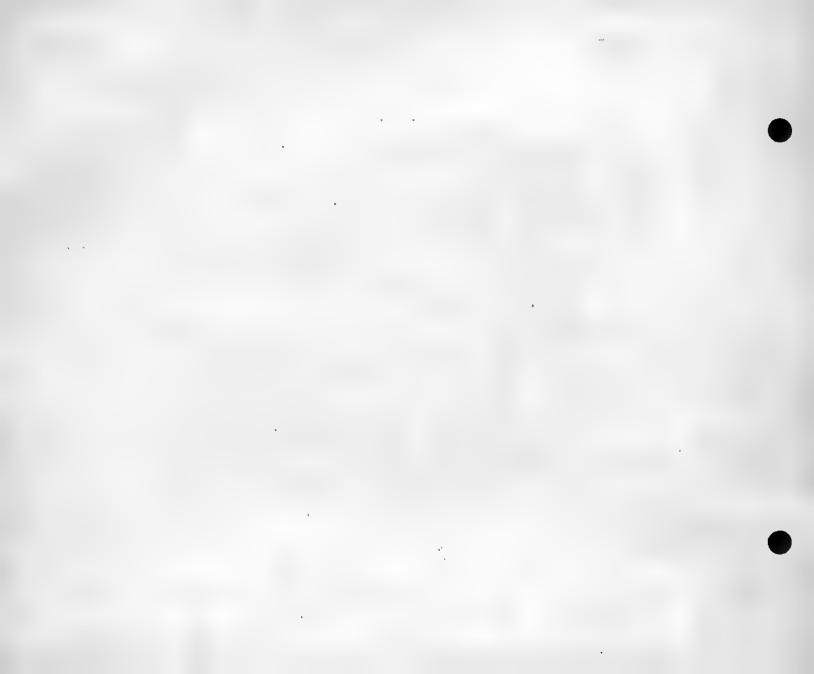
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 95376 05374 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death funeral I and Searth PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) p. COUNTY b. COUNTY Marvland Montgomerv Montgomerv MARYLAND by him Poges b CITY OR TOWN (If outside corporate limits, C LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) iely filled in by the ban papers. Page, within 72 hours a write RURAL and give nearest town) 26 days Spencerville d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS IS RESIDENCE ON A FARM? Montgomery General Hospital Batson Road 16000 NO P Pour 3 NAME OF Middle First Lost 4. DATE Month Year DECEASED April 2 19 67 Samuel Howes Leonard (Type or print) DEATH camp 6 COLOR OR RACE DATE OF BIRTH 7. MARRIED NEVER MARRIED 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS rending. birthday) Hours. Male White 5/6/14 any DIVORCED WIDOWED pup 10a USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT physician (nen please during most of work ng life, even if retired) and i Bottling Company COUNTRY S.A. Maryland 13. FATHER S NAME signed by the attending physi burial-transit permit Then pl burial, cremat.an, or remaval, 14 MOTHER'S MAIDEN NAME Samuel Howes Grace Howes 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17 INFORMANT Address (Yes no, or unknown) (If yes give wor or dotes of service) Hospital Records 1B CAUSE OF DEATH (Enter only one couse per line for (a), (b) and (c)) INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY ULHONAR IMMEDIATE CAUSE (o) DUE TO REMIA - CHRONIL RENAL DOUR Conditions, if any, which gove it (b) rise to immediate couse (a). DUE TO PERTENSIVE (YEDIOFASE. DIS stoting the underlying couse priar ta PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN WAS ALTOPSY PERFORMED? Health ABOLIC YES DA þ certificate 20o. ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) by the haspital OR CONTR BUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) MEDICAL 20c TIME OF INJURY Month, Day, Year FUNERAL DIRECTOR: After this 20d INJURY OCCURRED 2De. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour o.m. Not While foctory, street, office bldg., etc.) of work 21. I certify that (1) (this hospital) attended the deceased from 1964 10 Page 4 may be retained filed with the 1967, and that death accurred at 1:30 meters causes and an the date stated above. saw the deceased alive on A 220 SIGNATURE DATE SIGNED DIRECTOR PHYS. , page be filed 22d ADDRESS NAME (Type Sandy Spring, Md. directar, I shauld be 230 BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) (Stote) REMOVAL (Specify) Burtonsville. Md. 9 Burtonsville 24. FUNERAL DIRECTOR **ADDRESS** 2So. REC'D BY REGISTRAR REGISTRAR S SIGNATURE VR A15 (4) Francis H. Laytonsville. Md. Barber



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05377 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 haurs after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY **5 COUNTY** a. STATE Montgomeru MARYLAND Montagnery b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c CITY OR TOWN (if autside corporate limits, write RURAL and give nearest town) HEGRA d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) IS RES DENCE ON A FARM? d. STREET ADDRESS 2111 Hildarose Drive Hildarose YES NO S NAME OF Year Doy DECEASED Catherine Hudson April 30 (Type or print) 19 67 DEATH IF UNDER 24 HRS IF UNDER TYEAR SEX AGE (In years 6. COLOR OR RACE DATE OF BIRTH 7. MARRIED F NEVER MARRIED emave last birthdov) Manths Davs Haurs white Sept 9, 1898 temale WIDOWED DIVORCED 10b KIND OF BLSINESS OR INDUSTRY CHARACTER PRINCE 10o. USUAL OCCUPATION (Give kind of work dane 11 BIRTHPLACE (County & State, at fareign country) 12 CITIZEN OF WHAT COUNTRY? during most of working life even if retired)
Retired Trinmina Operator attending physician sermit. Then please 14 MOTHER'S MAIDEN NAME 13. FATHER'S NAME burial, cremation, or removal, George L. Emma Mahaney 17. INFORMANT WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO Address Drive (Yes, no, or unknown) (If yes give wor or dates of service Bernard A. Hudson No 18. CAUSE OF DEATH (Enter only one cause per fine signed by the burial-transit p PART I. DEATH WAS CAUSED BY: ONSET AND DEATH IMMEDIATE CAUSE (o) 4200 DUE TO Conditions, if only, which gave nse ta immediate cause (a), DUE TO stating the underlying cause as the priartal last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BLT NOT RELATED TO JETNIFE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY PERFORMED? NO. certificate 200 ACCIDENT WAS UNDERLYING Ob. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I at Part II af item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20d INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City or town) (County) (State) 20c TIME OF INJURY Month, Day, Year Hour o.m. factory, street, office bldg., etc) Nat While 21. I certify that (1) (this-hospital) attended the deceased fram FUNERAL DIRECTOR: saw the deceased alive an and that death accurred at 1. M, fram causes and an the date stated above 22a SJGNATURE director, page 3 shauld be filed v PHYS PHYS M.D. 22d ADDRESS NAME (Type) Curry 23c. NAME OF CEMETERY OR CREMATORY BURIAL, CREMATION DATE THEREOF REMOVAN (Specify) Forest Glen. Maryland John's Cemetery 2So. REC'D BY REGISTRAR 1967



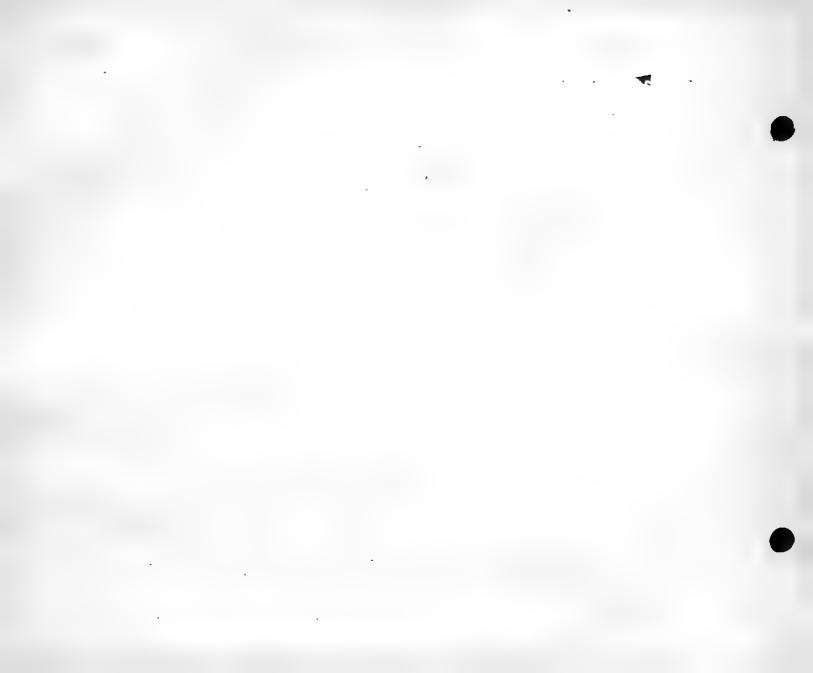
MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH and 2 death. PLACE OF BEATH USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. COUNTY b. COUNTY in and compately filled in by the f s remove carbon papers. Pages 1 in any events within 72 hours after MARYLANÔ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) OR INSTITUTION (of not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES within NAME OF Middle DATE Last Month Year DECEASED (Type or print) DEATH 19 executed DATE OF BIRT 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS AGE/(I/) years 7. MARRIEO NEVER MARRIED last birthday) Months Days Hours WIDOWED DIVORCED physician an please re 10b. KINO OF BUSINESS OR 10a. USUAL OCCUPATION (Give kind of work done BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT lease and in death certificate be during most of working life, even if retired) Insurance FATHER'S NAME MOTHER'S MAIDEN NAME remova SOLN in signed by the attend burial-transit permit. burial, cremation, or re WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY ND. (Yes, no, or unkown) | (If yes give war or dates of service) John J. 18. CAUSE OF DEATH [Enter only one cause per line for (a), INTERVAL BETWEEN law requires that the **ONSET AND DEATH** PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) attending physician. DUE TO Conditions, If any, which been gave rise to immediate as the l DUE TO cause (a), stating the underlying cause last. certificate has (c) CERTIFICATION WAS AUTOPSY PERFORMEO? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIDUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) nse for use Health he hospital or NO BO YES 20a, ACCIDENT WAS UNDERLYING OESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of Item 18.) detached for the detached for the Dept. of the OR CONTRIBUTING TI CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (State) (County) factory, street, office bldg., etc.) be de State DIRECTOR: After age 3 should be dilled with the State Hour a.m. While Not While at work at work _, to_4/-21. I certify that (I) (this hospital) attended the deceased from .1967, and that death occurred at 3 A saw the deceased alive on _M, from the causes and on the date stated above. 22a. SIGNATURE DATE SIGNED director, page 3 ATTENDING STAFF M.D. TO HOSPITAL TO FUNERAL 22d. ADDRESS Takoma 22c. PHYSICIAN NAME (Type) New Hampshire BURIAL, CREMATION, 23b. **OATE THEREOF** NAME OF CEMETERY OR CREMATORY LOCATION (City, town or county) REMOVAL (Specify) Removal **FUNERAL DIRECTOR** Sons Gawler's oaeph Inc VR A.15 (4) 20M 1/65

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| | MARYLAND STATE DEPARTMENT OF HEALTH |
|--|--|
| 1 | Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 |
| FOR STATE | 05380 #11,13 & 14 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05373 |
| HEALTH DEPT. | PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased I ved, if institution Residence before admission) o STATE Maryland b COUNTY Montgomery |
| delay is meniar meniar | |
| 2, and PMS. | b. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) Silver Spring 5 mins. C LENGTH OF STAY IN 1b C CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) White Oak |
| es 1, farm farm te De ours | d NAME OF HOSPITAL OR INSTITUT ON (If not in haspital, give street address) Holy Cross Hospital d STREET ADDRESS Holy Cross Hospital d STREET ADDRESS 11301 Stewart Lane on A FARM2 YES NOTE |
| after death 1. 3. Give Pages along with far with the State within 72 hours. | 3 NAME OF First Middle Last 4 DATE Manth Doy Year OF 10, April, 67 19 |
| D ao O 🔌 🛣 | Female Negro WIDOWED DIVORCED 10, Apr, 67 SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED 8 DATE OF BIRTH 9. AGE (In years of birthday) Months Days Haurs Magnetic Ma |
| | Wa USUAL OCCUPATION (Give kind at work dane during most of working life, even if retired) 10b. KIND OF BUSINESS OR II BIRTHPLACE (State ar fareign cauntry) White Oak, Mont. Co. |
| I within 24 in pencil in I Examiner's (Examiner's Caminer's and File pages I and in any | 13 FATHER'S NAME //////////////////////////////////// |
| executed vending!" in f Medical Ex ut perm.it. Fil | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, ar unknown) (If yes give war ar dates at service) 16. SOCIAL SECURITY NO. 17. INFORMANT HOSPital Records |
| ate should be e i the ward "per d to the Chief I a burial-transit crematian, or re | 18 CAUSE OF DEATH (Enter only one cause per profit (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Conditions, if any, which gave rise to immediate couse (a), stoting the underlying cause lost. (c) INTERVAL BETWEEN ONSET AND DEATH |
| s certifice e, writing farwarde s used as a burial, | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN N PART I(a) 19 WAS AUTOPSY PERFORMED? YES TO NO |
| INER: This e certificate, shauld be for files. 3 should be unit, prior tail | PRIMARY Or CONTRIBUTING CAUSE OF DEATH 200 EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING CAUSE OF DEATH 201 EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING CAUSE OF DEATH |
| AMIN e the e 4 sh qur fil age 3 s | 20c. TIME OF INJURY Manth, Day, Year Haur a.m. p.m. 19 20d INJURY OCCURRED While of wark at work of wark at work |
| ITY MEDICAL Ty, please exected director. Pose retained for SAL DIRECTOR. The designate of | 21. I certify that I took charge of the remains described obove, held an Autapsy , Inspection , Inquiry , and in my opinion death resulted from? Natural causes , Accident , Suicide , Hamicide , Undetermined manner , CHIEF MEDICAL EXAMINER , CHIEF MEDICAL EXAMINER , ASSISTANT M |
| TO DEPUTY necessary, the funeral 5 may be a TO FUNERAL Health or a | NAME (Type) (CEDEN), (CAPPIN), bodies ished dix (Mrn, or county) 23a. BURIAL (REMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OF REMATORY 27d, OCATION (City of Jown) (County) (State) 18 MOVAL (Specify) 11/2/67 Local Delawers Serving Line) |
| VR A 15ME (5) | 24 FUNERAL DIRECTOR Lysen Linealer Rockwille, Land, DAKPR 1 3 1967 yourseles younge |



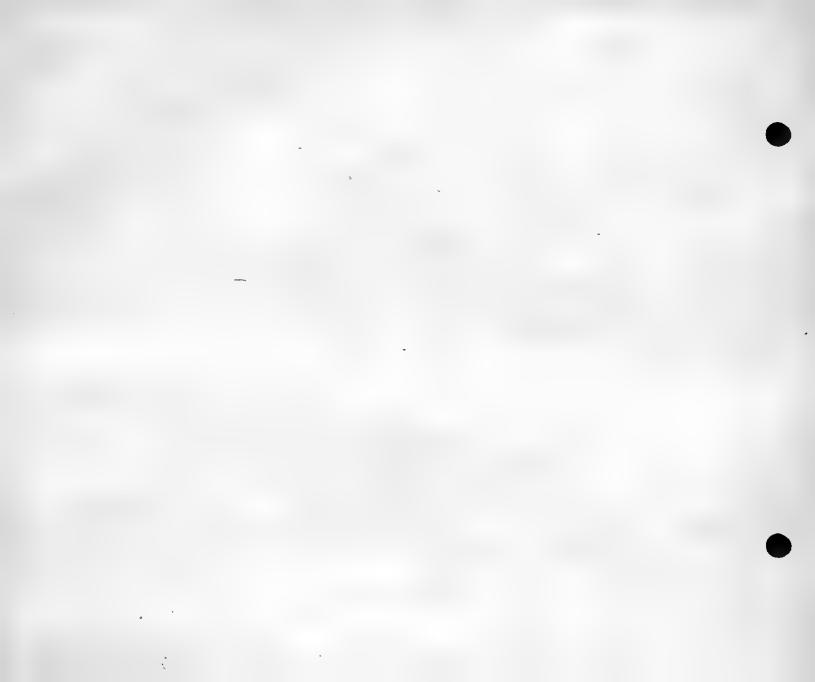
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 35381 within 24 hours after death. 2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) I. PLACE OF DEATH filled in by the funer papers. Pages I or o. COUNTY b. COUNTY o. STATE MARYLAND District of Columbia Montaomerv b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 15 Washinoton d STREET ADDRESS IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street oddress) University Nursing Home YES NO 🔽 2400 19th St., N.W.Apt. 901 Arcola Avenue NAME OF Middle 4. DATE First Lost Month Doy Year DECEASED (Type or print) William DEATH Andrew Irwin requires that the death certificate be executed S. SEX 6. COLOR OR RACE 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 7. MARRIED B. DATE OF BIRTH 1884 **NEVER MARRIED** remove lost birthdoy) Days Hours DIVORCED 12/6/1804 WIDOWED physician ond c male Caus. and in on 12. CITIZEN OF WHAT 10o USUAL OCCUPATION (Give kind of work done 106 KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired) **COUNTRY?** INDUSTRY teacher of theology Markdale, Ontario, Canada Canada 14 MOTHER'S MAIDEN NAME cremotion, or removol, Henry D. Irwin Mary Anne Cunningham IS. WAS DECEASED EVER IN U.S ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT (Yes, na, ar unknown) (If yes give war ar dates of service) NURSING HOME RECORDS No 458-50-7028-A INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) buriol-transit p PART I. DEATH WAS CAUSED BY: ONSET AND DEATH signed by IMMEDIATE CAUSE (o) DHE TO Canditions, if any, which gave rise to immediate couse (a), DUE TO stating the underlying couse the hospital or attending os the prior to this certificate hos been lost 19. WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) NO X ق 205 DESCRIBE HOW INJURY OCCURRED (Enter notuce of injury in Port 1 or Part II of Item 18.) 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e PLACE OF INJURY (Home, form, 20f. (City or town) (County) (Stote) Hour a.m. factory, street, office bldg., etc.) Not While of work at work O FUNERAL DIRECTOR: After Poge 4 moy be retoined by 21. I certify that (I) (this hospital) attended the deceased fram (at 1966, ta April -23 1967, that (I) (we) last saw the deceased alvo on April -23, 1967, and that death occurred at 1994 M, from causes and on the date stated above. 22o. SIGNATURE 22b. DATE SIGNED ATTENDING M.D. PHYS DIRECTOR PHYS. 22d. ADDRESS 20c. PHYSICIAN'S NAME (Type). 001 director, should be 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 230 BURIAL CREMATION. 23b DATE THEREOF (County) REMOVAL (Specify) ESEDRIFFER UNIV MED. Sufor 14457125 TON WHITMIICHL 24. EMNERAL DIRECTOR VR A15 (4) 20 M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 05382 PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before asm ssign) a COUNTY. o. STATE b. COUNTY MARYLAND b. CITY OR TOWN (If outside carparate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside carporate limits, write RURAL and give meases, town) write RURAL and give negrest town) d STREET ADDRESS d NAME OF HOSPITAL OR INSTITUTION (If not in haspital give street address) NAME OF Last 4. DATE Day DECEASED SN4 DEATH (Type or print) S SEX 9. AGE (In years IF UNDER 6 COLOR OR RACE 7 MARRIED NEVER MARRIED DATE OF BIRTH last birthday) Months Davs WIDOWED X DIVORCED 10b, KIND OF BUSINESS OR 12. CITIZEN OF WHAT The USUAL OCCUPATION (Give kind of work done 11 BIRTHPLACE (County & State, or fareign country) during most at working life, even if retired) INDUSTRY COUNTRY? USS 1A CCOND mis 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME IS. WAS DECLASED EVER IN U.S. ARMED FORCES? 17. INFORMANT (Yes, no, or unknown) (If yes give wor or dates of service) BETHESDA, MD INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a). DHE TO stating the underlying cause 19. WAS AUTOP PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMED? YES [NO 20d. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH 205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part II of item 18.) (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Hame, farm, 2Dd INJURY OCCURRED (City or fown) (County) (State) 2Dc. TIME OF INJURY Month, Day, Year factory, street, office bldg., etc.) at wark 21. I certify that (1) (this haspital) attended the deceased fram. 19____, ta_ ., 19____, that (I) (we) last __19____, and that death accurred at_ M, from causes and an the date stated above saw the deceased alive an. 22b. DATE SIGNED 227 SIGNATURE MED. DIRECTOR M.D. PHYS PHYS 22d. ADDRESS NAME (Type) MERTON L. WHITE 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 230. BURIAL, CREMATION, 23b DATE THEREOF (County) (State) REMOVAL (Specify)
REMOVAL (Specify)



DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05383 CERTIFICATE OF DEATH The law requires that the death certificate be executed within 24 hours ofter death 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution Residence o COUNTY o STATE b. COUNTY MARYLAND C LENGTH OF STAY IN 16 b CITY OR TOWN (If outside serporate limits c CITY OR TOWN (If passide corporate limits, write RURAL and give marest tawn) write RURAL and give bearest town d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) IS RESIDENCE d STREET ADDRESS within 72 h ON A FARM Hospital NO NAME DE Middle 4. DATE Year DECEASED 1967 (Type or print) DEATH IF UNDER 24 HRS IF UNDER 1 YEAR SEX 7. MARRIED AGE (In years lost birthday) Months Dovs Haurs WIDOWED DIVORCED 10o, USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 12 CITIZEN OF WHAT BIRTAPLACE (County & Stote_or foreign country) COUNTRY ? during most of working life, even if retired) INDUSTRY " hone usecus 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME or removal, 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dates of service) 16 SOCIAL SECURITY NO 17 INFORMANI 0.26-0601 cremation, 18 CAUSE OF DEATH (Enter only one couse per line for INTERVAL BETWEEN PART I DEATH WAS CAUSED BY: ONSET AND DEATH signed by t IMMEDIATE CAUSE (o) physicion. DUE TO burioi. Canditians, if any, which gove) rise to immediate couse (a). DUE TO far use os the l f Heolth priar to b stating the underlying cause by the hospital or attending hos been PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(0) WAS AUTOPS)
PERFORMED? NO YES T this certificate PHYSICIAN: 20o ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 at Port II af item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (CITY OF OWN) (Caunty) (Stote) Haur a.m. factory, street, affice bldg , etc) While Nat While at work at work 21. I certify that (I) (this haspital) attended the deceased fram Poge 4 moy be retained TO FUNERAL DIRECTOR: and that death accurred at 24 from causes and an the date stated above 22o SIGNATURE Apr 20-67 DIRECTOR director, page should be filed 22d. ADDRESS 11,000 old @eorgetown Rd.Rockville Md Thibadeau NAME (Type) Robert t. 23d LOCATION (City of Tawn) 230 BURIAL, CREMATION, 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY (Caunty) (State) REMOVAL (Specify) Rockville. Maryland VR A15 (4) 25M 1/67 DATE



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 35384 requires that the death certificate be executed within 24 hours after deap and 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission PLACE OF DEATH filled in by the funeral papers I and o. STATE Virginia a. COUNTY b. COUNTY Montgomery MARYLAND CLENGTH OF STAY IN 16 c CITY OR TOWN (if gutside corporate limits, write RURAL and give negrest town) b CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town)
Bethesda 19 days Reston d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS e. IS RESIDENCE ON A FARM? 1702 Shagbark Circle The Clinical Center, Bethesda, Md. 20014 YES T NO X 3. NAME OF First Middle Last 4. DATE Month Year Day completely DECEASED April 19 67 11 Carl Emerson Johnson (Type or print) DEATH IF JNDER I YEAR IF JNDER 24 HRS. S SEX 6. COLOR OR RACE 8 DATE OF BIRTH AGE (In years 7. MARRIED **NEVER MARRIED** rembye last birthday) Months Haurs Male Negro 20 November 1920 WIDOWED DIVORCED signed by the attending physician and burial-transit permit Then please Pem burial, crematian, ar remaval, and in on 1Da USUAL OCCUPATION (Give kind of work dane during mast of working life, even if retired) 11. BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT IDE KIND OF BUSINESS OR INDUSTRY COUNTRY? USA Virginia Accountant Government 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Alberta Coles Louis Johnson 17. INFORMANT The Medical Recordisess IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give wor or dotes of service)
Yes 1942-45,1952-44 098-12-2493 The Clinical Center, Bethesda, Maryland 20014 INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Cardiorespiratory collapse ONSET AND DEATH DUE TO Conditions, if any, which gave (b) Severe Glucose Deficiency 12 hours rise ta immediate cause (a), DUE TO r this certificate has been si detached far use as the b te Dept. af Health prior ta b stating the underlying cause (d) Fibrosarcoma 2 years lost. 19 WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) YES 🔻 NO 2Do ACCIDENT WAS UNDERLYING 205. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 2Dd. INJURY OCCURRED 20e PLACE OF INJURY (Hame, form, (City or town) (County) (State) 20c TIME OF INJURY Month, Day, Year factory, street, affice bldg, etc.) at wark at work O FUNERAL DIRECTOR: After 2). I certify that \$0 (this haspital) oftended the deceased fram March 23 , 19 67, ta April 11, 19 67, that \$5 (we) last be retained saw the deceased alive on April 11. 1967, and that death accurred at 5:00 M, fram causes and an the date stated above. 22b. DATE SIGNED 22a. SIGNATURE ATTENDING STAFF PHYS. 12 March 1967 M.D. DIRECTOR 22c. PHYSICIAN'S NAME (Type) 22d ADDRESSThe Clinical Center National director, ∏o should be f Joel Rubenstein, M.D. Institutes of Health, Bethesda, Md. 20014 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 23a. BURIAL, CREMAT ON, 23b DATE THEREOF (County) (State) BIREMOVAL (Specify) Birmingham, Ala. h/67 Grace Hill 25b. REGISTRAR'S SIGNATURE JUNGE 24. FUNERAL DIRECTOR 2So. REC'D BY REGISTRAR VR A15 (4) Franklin St. Alexandria APR 1 20 M 1/66 Home.



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item #9 CERTIFICATE OF DEATH 35385 death. death. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. COUNTY o. COUNTY MARYLAND carban papers. Pages 1 requires that the death certificate be executed within 24 hours after campletely filled in by the T c. LENGTH OF STAY IN 1b c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b CITY OR TOWN (If outside corporate limits, e RJRAL and give nearest town 8 mo O CK e IS RESIDENCE ON A FARM? d. STREET ADDRESS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sing YES NO L Middle NAME OF 4. DATE First Doy Year DECEASED OF 196 (Type or print) DEATH Q PAGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. SEX 6 COLOR OF RACE 7. MARRIED NEVER MARRIED removil Manths Haurs Davs WIDOWED DIVORCED and in any signed by the attending physician and burial-transit permit. Then please re-12. CITIZEN OF WHAT 10o USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTMPLACE (County & State, or foreign country) COUNTRY 27 during most of working life, even if retired) INDUSTRY MONIE 13. FATHER'S NAME MOTHER'S MAIDEN NAME WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17. INFORMANT (Yes, na, ar unknown) ((If yes give wor ar dotes of service) D.C. DAKNOWN INTERVAL DETEVEEN 18. CAUSE OF DEATH (Enter an y one cause per line for (o) SWEET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove (b) rise to immediate cause (a), DUE TO stating the underlying cause Page 4 may be retained by the haspital ar attending as the priar ta O FUNERAL DIRECTOR: After this certificate has been last. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART !(a) ed far use of Health p NO 200 ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port 1 or Port 11 of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER ed with the State Dept. 20e. PLACE OF INJURY (Home, farm, (City or town) (County) (State) 20d INJURY OCCURRED 20c. TIME OF INJURY Manth, Doy Year factory, street, affice bldg., etc.) Hour o.m. Not While at work 19 of work 21. I certify that (I) (this haspital) attended the deseased from and that death accurred at PM, fram causes and an the date stated above sow the deceased alive an 220. SIGNATURE 22b. DATE SIGNED MED. DIRECTOR ATTENDING director, page shauld be filed 22d. ADDRESS 22c. PHYSICIAN S NAME (Type) G. Blud. 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stofte) BURIAL, CREMATION, 236 DATE THEREOF CREMOVAL (Specify) CREMATORY 2So. REOD BY REGISTRAR REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR VR A15 (4) %



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05386 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. COUNTY, Montgomery ontgomery Maryland MARYLAND b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Takoma Park c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park D.O. A. d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS Washington Sanitarium & Hospital 7409 Aspen Avenue NO TE 3. NAME OF LAWRENCE (Type or print) 4. DATE Rush Johnson April 20 19 67 DEATH 6 COLOR OR RACE B. DATE OF BIRTH IF JNDER 1 YEAR IF UNDER 24 HRS. 7 MARRIED XX NEVER MARRIED 9 AGE (In years birthdoy) Sept. 8,1918 White Male WIDOWED DIVORCED 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Bullider 10b. KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (County & State or foreign country) 12 CIT ZEN OF WHAT Kentucky 14. MOTHER'S MAIDEN NAME Mabel Straw Johnson IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give war or dates of service) Mrs. Tressa C. Johnson same 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c)) INTERVAL BETWEEN signed by the PART I. DEATH WAS CAUSED BY. ONSET AND DEATH. IMMEDIATE CAUSE (a) DUE TO Conditions, if only, which gave : rise to immediate cause (a), **DUE TO** stating the underlying couse 19 WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GOVEN IN PART 1(a) NO 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (Gty or town) (County) (State) Hour 'o.m. foctory, street, office bldg , etc.) 21. I certify that (i) (this hospital) attended the deceased from Section 1966 to Ceprel and that death occurred at 135 a.M., from causes and an the date stated above. TO FUNERAL DIRECTOR: saw the deceased alive an_ 22o. SIGNATURE 22b DATE SIGNED DIRECTOR director, should b 23o. BURIAL, CREMATION. 2Sb REGISTRAR" VR A15 (4) 25M 1/67

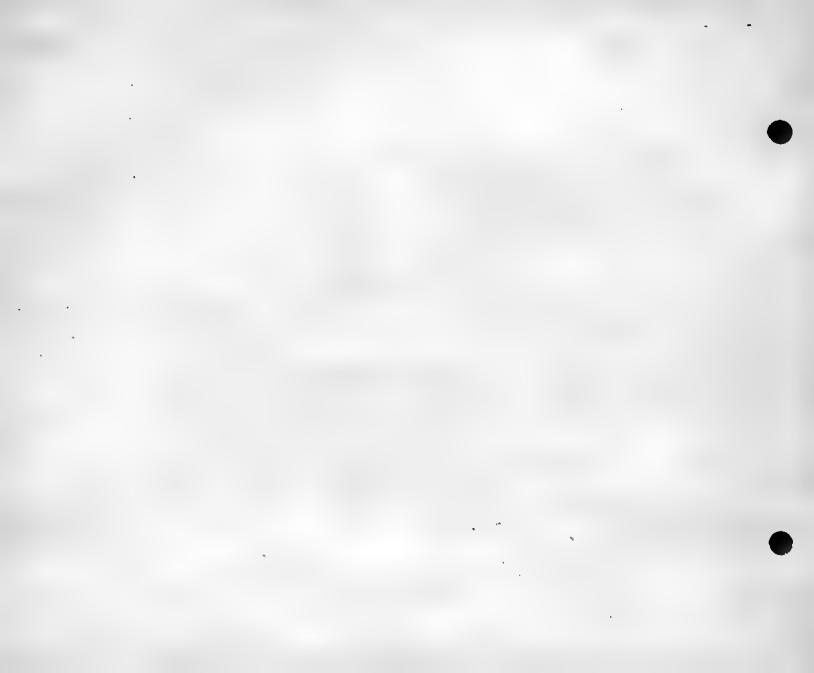


MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05385 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 35387 PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. COUNTY State Department of MARYLAND b. CITY OR TOWN (If outside corporate limits) C LENGTH OF STAY IN 1h c CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) write RURAL ong ve neorest town d STREET ADDRESS e IS RESIDENCE ON A FARM? d NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) farm 10518 YES NO X This certificate should be executed within 24 hours after death. With NAME OF Middle Year DECEASED OF DEATH 19 6 (Type or print) alang AGE (IF IF UNDER 1 YEAR F UNDER 24 HRS 5 SEX VAOTS 6 COLOR OR RACE 7. MARRIED NEVER MARRIED lest birthdoy) Months D VORCED and in any event within 72 hours after death WIDOWED e certificate, writing the ward "pending" in pencil in Item 1 should be farwarded to the Chief Medical Examiner's Office permit. File pages land 12. CIT ZEN OF WHAT 10b KIND OF BUSINESS OR RIRIMPLACE (State or foreign country) 10a USUAL OCCUPATION (Give kind of work done duting most of working life, even if retired) INDUSTRY COUNTRY? Author 13 FATHER'S NAME 14 MOTHER'S MAIDEN NAME Unknown 16. SOCIAL SECURITY NO 17 INFORMANT Wife IS. WAS DECEASED EXER IN J.S ARMED FORCES? Address (Yes, no, or unknown) (If yes give wor or dates of service) 78-30-7669 Same as Item 2. Iris D. Jones 18 AIJSE OF DEATH (Enter only one couse per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY. INTERVAL BETWEEN NET AND DEATH Coronaly Insufficency Acuta IMMEDIATE CAUSE (o) Cardio Vascular Disease. DUE TO Conditions, if any, which gave nse to immediate couse (a), DUE TO stoting the underlying couse 0 90 be used 19 WAS AUTOPS'
PERFORMED? removal, PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) CERTIFICATION NO T 200 EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Part 11 of Item 18.) 3 shauld crematian, ar PRIMARY Or CONTRIBUTING MEDICAL EXAMINER: CAUSE OF DEATH. files. 20c TIME OF INJURY Month, Day, Year 20d. NJJRY OCCURRED 20e PLACE OF INJURY (Home, form, 20f (City or town) (Stote) Hour o.m. factory, street, office bldg., etc.) of work 21. I certify that I taak charge of the remains described above, held an Autopsy Inspection 💢 Inquiry XI, and in my apinian may be retained for FUNERAL DIRECTOR: Natural causes XX. Accident 🗔 Suicide 🗔 Hamicide 🗍 death resulted fram. Undetermined manner he funeral directar CHIEF MEDICAL EXAMINER **ACTUAL** 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER ... Health prior SIGNATURE DEPUTY MEDICAL EXAMINER | The control of the contro **EXAMINER'S** John G. Ball esda. Md. Address (Street, city, town, or county) NAME (Type) 23d LOCATION (City or Town) 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23o. BURIAL, CREMATION, (County) 0 Burial (Specify) 4-17-67 Alexandria Natl Cem. Alexandria. Virginia Maryland PR 13 19 Bethesda.



| | Lt | m 18 Film 388 5-5 | -67 a:MARYLAND STATE DEPARTMENT OF HEALTH | |
|--|-----------------|--|---|----------------------------------|
| - 175m | | | ICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 2 | 1201 |
| FOR STATE | | 05388 | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | 5386 |
| HEALTH DEM | | LACE OF DEATH | 2 USUAL RESIDENCE (Where deceosed lived, if institution Resid | dence before admission) |
| 3 ta 3 ta Page nt o | | Mon (asm | Cry MARYLAND O. STATE D. COLINIY | about mery |
| delay and 3 M3. Pag tment | | CITY OR TOWN (f outside corporate I mits write RURAL and give neares frown) | c LENGTH OF STAY IN 16 C. CITY OR TOWN (If outside corporate limits write RURAL and c | |
| ry delay is 2, and 3 ta PM3. Page nortment o | ے | 11 Wer JOHIY | 15 This Whenton 10 | 1/ |
| | | · · / ~ /. | d. STREET ADDRESS | e S RESIDENCE ON A FARM? |
| Pages 1, 2, and 3 tith farm PM3. Pages 5, 2, and 3 tith farm PM3. Pages 5 tate Department of baurs after death | - | loly Cross Hos | pot S.l. Spg. 8210- Lingston | JY YES NO |
| With Page | | NAME OF F.IS | Middle Jost BATE Month | Doy Year |
| after de 8. Give P alang wi with the | S. | Type or print) 6. COLOR OR RACE | | ER 1 YEAR 1 IF UNDER 24 HRS. |
| ns aff | | e ale ohite | WIDOWED DIVORCED 3-29-07 lost birthdoy) Months | |
| hin 24 haurs ncil in Item I niner's Office pages I and? in any even | | USUAL OCCUPATION (Give kind of work doneing most of working life, even if retired) | INDUSTRY | CITIZEN OF WHAT |
| thin 24 acil in 1 niner's pages 1 in any | 13 | FATHER'S NAME | Own ho: | 0021 |
| s within in penci Examin Examin F le pa | | Pobert Had an | Gartxide Poed | |
| INER: This certificate should be executed within 24 hours after death if should be certificate, writing the ward "pending" in pencil in Item 18. Give Pages 1, should be farwarded to the Chief Medical Examiner's Office along with farm files. 3 should be used as a burial-transit permit FIe pages land? with the State Depart, prior to burial, cremation, or remayal, and in any event where 7th hours. | 15. (Ye | WAS DECEASED EVER IN U.S ARMED FORCES? i, no, or unknown) (If yes give wor or dotes of | service 16. SOCIAL SECURITY NO. 17. INFORMANT 1210 Address in | rosto · St |
| exe endi f Me it pe | | 18. CAUSE OF DEATH (Enter only one cous PART I. DEATH WAS CAUSED BY: | se per line for (a), (b), ond (c).) | INTERVAL BETWEEN ONSET AND DEATH |
| t be d 'p d' p Chie | | / IMMEDIATE CAUSE (| | 1 hr. |
| ould ware he (he) ial-t | | OUE 1 Conditions, if any, which gove 1 | Myocardial runture and cardiac Tamponade | 1 hr. |
| sh the tat bur | | rise to immediate couse (a), | · / | |
| icate ng 1 ded ded as a | | stating the underlying couse | d Acute myocardial infarction | 8-9 hrs. |
| This certificate, writing for farward | × | PART IL OTHER SIGNIFICANT CONDITIONS CO | ONTR BLTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) | 19 WAS AUTOPSY PAGEORMED? |
| his ate, e fai | CATI | | | YES NO |
| INER: The certifice should be files. 3 should be files. | L CERTIF CATION | 200 EXTERNAL CAUSE WAS PRIMARY ☐ OF CONTRIBUTING ☐ CAUSE OF DEATH | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part II of item 18.) | |
| ₹ + + + = a a a | MEDICAL | 20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 | 20d NJJRY OCCURRED 20e PLACE OF INJURY (Home, form, While otwork of work of work of work of work) | (State) |
| L EXA cecute Page for you | | * | af the remains described above, held an Autopsy 🔀, Inspection 🔼, Inquiry 🗌 | , and in my opiniar |
| e e e e e e e e e e e e e e e e e e e | | death resulted from. Natural | causes [], Accident [], Suicide [], Homicide [], Undetermined manner | |
| o DEPUTY MED. (A) necessary, please ex the funeral director. S may be retained f D FUNERAL DIRECTO Health or its design. | | ACTUAL SIGNATURE SO PO | CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER | 22. DATE SIGNED |
| TTY TY, Ferd Ferd Se r SAL Sor it | | A STATE OF THE STA | DEPUTY MEDICAL EXAMINER | 40 6- |
| o DEPUTY necessary, the funera 5 may be 0 FUNERA! | | NAME (Type) Ohza J. | COQUIS MD 1918 Je Address (Street, and tour page country) | 7-2-3-07 |
| TO C nece the 5 m | 230 | BURIAL, CREMATION, 23b. DATE THER | | (County) (State) |
| | 0.24 | FLNERM DIRECTOR MAS SOLUT | ADDRECS - DEC'D BY DECISTRAD JOSE DECISTRAD | 7 |
| VR A15ME (5) 6M 1/66 | 10 | Truer & Pumphrey | Thomas 213. Goorcia 4-12 re DATEPR 27 1967 ACCOM | |

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 05383 law requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, is institution: Residence before admission) o. COUNTY o. STATE ъ. COUNTY MARYLAND c. LENGTH OF STAY IN 16 b CITY OR TOWN (If outside comparate limits write; RURAL and give negrest town) and completely filled in by the remave corbon papers. Page: in profession, within 72 haurs of e IS RESIDENCE ON A FARM? d. STREET ADDRESS d NAME OF HOSPITAL (If not in hospital, give, street address) 2316 NO V YES DATE NAME OF Middle Month Doy First Year DECEASED 0F 19 DEATH (Type or print) DATE OF BIRTH 9. AGE In years IF UNDER 1 YEAR IF LINDER 24 HRS S. SEX 7 MARRIED **NEVER MARRIED** last birthdoy) Months Dovs Hours WIDOWED DIVORCED 10b, KIND OF BUSINESS OR 12. CITIZEN OF WHAT 100, LSUAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (County & Stote, or foreign country) during prote of working life, even if retired) GOUNTRY/P INDUSTRY physician on please ond 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME ar remaval WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO INFORMANT Address (Yes, no, or unknown) (If yes give war or dates of service) burial, cremation, 18. CAUSE OF DEATH (Enter only one couse per inne for (a), (b), and (c)) INTERVAL BETWEEN ONSET AND DEATH -transit PART I, DEATH WAS CAUSED BY. signed by t burial-trans IMMEDIATE CAUSE (o Conditions, if any, which gove rise to immediate couse (a), DUE TO stoting the underlying couse Health prior ta has been the WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) USe NO YES TO FUNERAL DIRECTOR: After this certificate far 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 18.) 2Do ACCIDENT WAS UNDERLYING by the hospital be detached for State Dept. of H OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) (Stote) 20d INJURY OCCURRED (City or town) 20e PLACE OF INJURY (Home, form, (County) 2Dc. TIME OF INJURY Month, Doy, Yeor foctory, street, office bldg. etc.) Hour o.m. Not While ot work ot work 21. I certify that (I) (this hospital) extended the deceasell from thot (I) (we) lost be filed with the be retained 30 Much 1967 and that death accurred of 234A-M, from causes and on the date stated above. sow the deceased etive on 220 SIGNATURE ATTENDING M.D. PHYS. DIRECTOR PHYS 22d **ADDRESS** 22c. PHYSICIAN S NAME (Type) director, should be LOCATION (City of Jown) (County) (Store) BURIAL, CKEMP 23b DAJE THEREOF NAME OF CEMETERY OR CREMATORY 230 BURIAL, CREMATION FUNERAL DIRECTOR VR A15 (4) 20 M 1/66



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH The law requires that the death certificate be executed within 24 hours after death. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence a COUNTY a STATE b. COUNTY low Gomeru MARYLANO the ottending physician and completely filled in by the sit permit. Then please remove-carbon papers Pages C LENGTH OF STAY IN 16 CITY OR TOWN (If outside corporate limits, c CITY OR TOWN (If outside comparate limits, write RURAL and give nearest town hours (write RJRAL and give nearest town 45 min JILVER papers d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? YES NO ! NAME OF DATE Month lost Doy Year DECEASED 2 1967 homas KEMPF DEATH (Type or print) IF UNOER 1 YEAR AGE (n years IF UNDER 24 HRS SEX 6 COLOR OR RACE B. DATE OF BIRTH 7. MARRIED NEVER MARRIED Months Days Hours WIDOWED DIVORCED yno ni bno 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & Stote, or foreign country) 12 CITIZEN OF WHAT 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INDUSTRY COUNTRY? Washington, D
14 MOTHER'S MAIDEN NAME Vone 13 FATHER'S NAME burial, cremation, or removal, Nancy Welmeyer IS SOCIAL SECURITY NO 17. INFORMANT WAS DECEASED EVER IN L. S. ARMED FORCES? Thistle Drive (Yes, na. or unknawn) (If yes give wor or dotes af service) Robert 3. Kempt None Marulano luer Sprina NTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c)) Page 4 may be retained by the naspirar or orrespond by the TO FUNERAL DIRECTOR: After this certificate has been signed by the ONSET AND OFATH PART I. DEATH WAS CAUSED BY: Cerebral edema IMMEDIATE CAUSE (a) DUE TO Acute yellow atrophy of liver Conditions, if any, which gove rise ta immediate cause (a). DUE TO stating the underlying couse State Dept. of Health priar to Viral hapatitis PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTÖPS PERFORMEO? YES K NO 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of Item 18.) 200 ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER (City or town) (State) 20c. TIME OF INJURY Manth, Doy, Year 20d. INJURY OCCURREO 20e, PLACE OF INJURY (Home, form, (County) foctory, street, office bldg., etc.) Not While ot work at wark 19 64 to CLOUL 2, 19 6 / that (1) (we) last 21. I certify that (1) (this-hospital) attended the deceased fram_ 6-16 191-7, and that death accurred at RIASPM, from causes and an the date stated above saw the deceased alive an Carel 220 SIGNATURE 22b. DATE SIGNED ATTENDING PHYS DIRECTOR PHYS. M.D. director, page should be filed ADDRESS 22c PHYSICIAN'S NAME (Type) Carolyn Pincock, M.D. 1944 Seminary Rd., Silver Spring, Md. 23d LOCATION (City or Town) 23c NAME OF CEMETERY OR CREMATORY 23b OATE THEREOF (Stote) 23a BURIAL, CREMATION, REMOVAL (Specify) Parklawn Cemetery Rockville, Maryland 2So REC'O BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE Milanley 20 M 1/66 SALUER SPARAGE



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 0538905391 CERTIFICATE OF DEATH The law requires that the death certificate be executed within 24 haurs after death the funeral ages 1 and PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE WEST WORKS TO WAR TO MONTE OF THE STATE OF THE STAT o. COUNTY Montgomery MARYEAND by the ru b CITY OR TOWN (If autside corparate limits, write RURAL and give nearest town) CLENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) completely filled in by the ave carban papers. Page y eyent, within 72 hours of Sumner, Chevy Chase 6 weeks Rockville d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) e. IS RESIDENCE ON A FARM? d STREET ADDRESS completely filled NO X 5016 Wyandot Court Potomac Valley Nursing Home 3. NAME OF Middle 4 DATE Last Month Doy Year DECEASED OF DEATH 1967 Kennedv April Evelvn (Type or print) 9 AGE (In years IF UNDER 1 YEAR | IF UNDER 24 HRS 6. COLOR OR RACE 7 MARRIED 8 DATE OF BIRTH NEVER MARRIED remave last burthday) April burial, crematian, ar remaval, and in any WIDOWED T DIVORCED Female 10g USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR 12 CITIZEN OF WHAT 1). BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired)

Housewife

13. FATHER'S NAME COUNTRYS INDUSTRY physician Columbus, Ohio 14. MOTHER'S MAIDEN NAME Ferdinand George Frank Mary Jaeger 17. INFORMANT 16. SOCIAL SECURITY NO. Address Mrs. Carlotta H. Johnston INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) signed by the burial-transit p ONSET AND DEATH PART I, DEATH WAS CAUSED BY: 2 re 6 vnl ANOXIA IMMEDIATE CAUSE (g) Page 4 may be retained by the haspital ar attending physician. 354X DUE TO Cerebizl Atherosclavosis Conditions, if any, which gave rise to immediate cause (a), DUE TO Atherosclavosic stoting the underlying couse PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(g) WAS AUTOPS PERFORMED? MONE NO S 20g ACCIDENT WAS UNDERLYING [1] 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part 1 or Part 11 of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, (City or tawn) (County) (Stote) 20c. TIME OF INJURY Month, Day, Year Haur a.m. factory, street, affice bldg., etc.) Nat While ot work TO FUNERAL DIRECTOR: After 21. I certify that (1) (this haspital) attended the deceased fram Nove 25, 1965, to 17 April, 1967, that (1) (we) las saw the deceased alive an 17 Maril 1967, and that death accurred at 5.45 P. M. fram causes and on the date stated above 22b. DATE SIGNED 22o. SIGNATURE MED DIRECTOR ATTENDING M.D. PHYS 8218 Wisconsin Ave. Bety md 22c. PHYSICIAN'S NAME (Type) 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 23b. DATE THEREOF (County) 23a. BURIAL CREMATION. REMOVAL (Specify) Rock Creek Cemetery Wash Washington Micheles Judge VR A15 (4) 20 M 1/66 Joseph Washington, D.C.

| 3 4 | | - 1 | Ιt | em 18 Film 388 5-8-6 MARYPAND STATE DEPARTMENT OF HEALTH | |
|---|---|-----|---------------|--|---------------------------------|
| V 1 | | | | Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MA | RYLAND |
| FOR S | TATE | | | 95392 MEDICAL EXAMINER'S CERTIFICATE OF DEATH | 5390 |
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| | permit. removal | | | The same party | INTERVAL DETWEEN |
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| O DEPUTY please er director. | FUNERAL f Health o | ^ | 23a | BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or cou | nty) (State) |
| 5 P. B. B. | 50 | 1 | C | remation Apr 24, 1967 Fort Lincoln Crematory Prince Georges (| o. Md. |
| | 1 | 100 | 24 | FUNERAL DIRECTOR CHICAGO SULTANDESS STAR 250. REC'D BY REG.STRAR 250. RECISTRAR | |
| VR AIS | 5ME (5) 1/65 | 1 | W | irrer E. Pumphrey. Inc. Silver Spring. Nd. DATE R 27 1967 Icharle | a Judge |
| | 1,40 | 37 | | | |



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DEPT PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. COUNTY b. COUNTY a. STATE Montgomery Arlington Virginia MARYLAND y delay as necessary, and 3 to the funeral 43. Page 5 may be b. CITY OR TOWN (If outside corporate limits, c. CITY OR TOWN (If outside corporete limits, write RURAL end give nearest town) C. LENGTH OF STAY IN 1b Departme write RURAL and give nearest town) Arlington 20/15 I 5/200 e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADORESS Riva. State hours 1705 S. Quincey Street NOX. YES NAME OF DATE Month Year Middle Last DECEASED 2, at PM3. April 1, ROY KINNEY A. 167 DEATH (Type or print) with 5. SEX 6. COLOR OR RACE AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS. DATE OF BIRTH 2 with 7. MARRIED 3 NEVER MARRIEO [last birthdey) Months Deys Hours Male White June 6, 1940 WIOOWEO OLVORGED event event 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INDUSTRY 12. CITIZEN OF WHAT 11. BIRTHPLACE (State or foreign country) COUNTRY? Give Installing Furnaces US Mechanic Marvland 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME E.5 Harold Kinney Priscilla Coleman File 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Address 17. INFORMANT 16. SOCIAL SECURITY NO. permit. removal, should be executed within word "pending" in pencil is Chief Medical Examiner's 216--38--1711 Margaret E. Kinnev-Item # 2 INTERVAL BETWEEN 18. CAUSE DF DEATH (Enter only one cause per line for (a), (b), and (c),] ONSET AND DEATH PART I. DEATH WAS CAUSED BY: burial-transit IMMEDIATE CAUSE (a) とりひく DHE TO ない:17. Drowning Conditions, if any, which (b) gave rise to immediate DUE TO cause (a), stating the ¢ underlying cause last. WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e) CERTIFICATION PERFORMED? NO X YES [Since 20a. EXTERNAL CAUSE WAS PRIMARY TO OF CONTRIBUTING CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of Injury in Part I or Part II of Item 18.) o e 3 should agent, pri 024- SWB171 Ped and uso Thrown in Rever and drowned. MEDICAL 120e, PLACE OF INJURY (Home, ferm, (City or town) (County) (State) 20d. INJURY OCCURRED 20c. TIME OF INJURY Month, Day, Year factory, street, office bldg., etc.) Bealls Island Mari Not While at work While River . CTOR: Page designated at work L inquiry 2. 21. I certify that I took charge of the remains described above, held an Autopsy Inspection X, and in my opinion Fles. DIRECTOR: Accident X Suicide Homicide Undetermined manner death resulted from: Natural causes CHIEF MEDICAL EXAMINER for your Page 22. DATE SIGNED **ACTUAL** ASSISTANT MEDICAL EXAMINER SIGNATURE director. Paretained for DENNERAL D OEPUTY MEDICAL EXAMINER DEPUTY **EXAMINER'S** Address (Street, city, town, or county) NAME (Type) John G. 23c. NAME OF GEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) BURIAL, CREMATION, 23b. DATE THEREOF REMOYAL (Specify) 4-16-67 Frostburg. St. Michaels Cemetery Md ... REGISTRAR'S SIGNATURE Burial REC'D BY REGISTRAR | 250. Frostburg, 24. FUNERAL DIRECTOR Md. Joseph R. Durst, Sr., John Judge VR A15ME 3500 4-64



DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 05394 The taw requires that the death certificate be executed within 24 haurs after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY b COUNTY o STATE Montgomery Maryland Montgomery MARYLAND b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 16 c CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) write RURAL and give negrest town) Rockville DOA d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS IS RESIDENCE ON A FARM? 13906 MarianhaDr. Holy Cross Hospital YES NO A NAME OF 4. DATE Middle Month Year DECEASED (Type or print) Knott 10 67 April Rosita Catherine DEATH IF UNDER 24 HRS 5. SEX DATE OF BIRTH AGE (In years IF UNDER 1 YEAR 6. COLOR OR RACE 7. MARRIED NEVER MARRIED lost birthdoy) Months 1/22/39 Female White WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 1) BIRTHPLACE (County & State, or fareign country) 12 CITIZEN OF WHAT during most of warking life, even if retired) COUNTRY? INDUSTRY attending physician sermit. Then please U.S.A Cabaldo, Italy Housewife 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME crematian, or remaval, Armida Yanutolo Yon Emilio Yon 17. INFORMANT Husband, 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. Address (Yes, no, or unknown) (If yes give war or dates of service Unknown Robt. E. Knott 13109 Marianna Dr. Rkvl..Md INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c))
PART 1. DEATH WAS CAUSED BY: signed by the burial-transit ONSET AND DEATH avellac. MMEDIATE CAUSE (o) DUE TO HEART FAILUR burial, COMGESTIVE Canditions, if any, which gave rise to immediate couse (o), DUE TO stoting the underlying couse YEAR CHRONIC UREMIA WAS AUTOPSY PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) PERFORMED? MEPHTROCALCINOSIS PERTENSION NO DO 200 ACCIDENT WAS UNDERLYING IT 20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Part I or Port II of item 18) OR CONTRIBUTING CAUSE OF DEATH detached te Dept. af (IF EITHER, NOTIFY MEDICAL EXAMINER 20c TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or fown) (County) (Stote) Hour 'o.m. Not While foctory, street, affice bldg., etc.) of work of work 2) I certify that (1) (this haspital) attended the deceased fram OCTDISER, 1968, to MARCH 2, 1967, that (1) (vers) last saw the deceased alive an ... WHECH 2 1967, and that death accurred at 7.40 P. M. fram causes and an the date stated above. 22b. DATE SIGNED 220 SIGNATURE MED DIRECTOR M.D 22d. ADDRESS 22c. PHYSICIAN'S MONTROSE AVE BETHESDA NAME (Type) 10427 230 BURIAL, CREMATION. 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Tawn) (County) Burial (Specify) Silver Spring, Maryland Gate of Heaven Cem. 4-6-67 250 RECD BY REGISTRAR 24. FUNERAL DIRECTOR PUMPHREY. Bethesda. Maryland



| | MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND |
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| £ 20.5 | 05395 CERTIFICATE OF DEATH 05393 |
| death. umeral and 2 death. | 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) 3. STATE 4. COUNTY 5. COUNTY 6. STATE |
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| ☆ (電道 え 2 | OF (Type or print) WILLIAM (KOHLER DEATH APRIL 4th 1967 |
| executed wand complements of any executed was carrently any executed was a second of the control | 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 19. AGE (In years FUNDER 1 YEAR FUNDER 24 HRS. Hours Min. |
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| the sit the mat | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: CARDIAC ARXIVED BY: CARDIAC ARXIVED BY: |
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| v requirently require some property of the pro | cause (a), stating the OUE TO ARTERIOSCLEROSIS |
| N: The faw requires that tall or attending physician ifficate has been signed befor use as the burial-trans. Health prior to burial, ore | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO OR CONTRIBUTING CAUSE OF DEATH OR CONTRIBUTING CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER) |
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| NG PHYSICIAN: by the hospital for this certific be detached state Dept. of H Exem | 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) 4 work 20f. 20f. (City or town) (County) (State) 20f. (City or town) (County) (State) 20f. (City or town) (County) (State) 20f. (City or town) (County) (County |
| ENDING P lined by t lined by t Re: After ould be d the State | 21. I certify that (I) (this hospital) attended the deceased from 1955, 19, to 4-4, 1967, that (I) (well-last |
| OR ATTENDIN y be retained I DIRECTOR: Af age 3 should the Siled with the S | saw the deceased alive on 4-3- 1967, and that death occurred at 5 M, from the causes and on the date stated above. |
| DIRI Bed 1 | Samuelt Fellman M.O. ATTENDING MED. STAFF DIRECTOR PHYS. 1 4-4-67 |
| HOSPITAL age 4 may FUNERAL rector, pa could be fill | PHYSICIAN'S NAME (Type) SAMUEL A. HILLMAN, M.D. 22d. ADDRESS 8829 Flower Avenue Silver Spring. Maryland 20901 |
| TO HOSPITAL OR Page 4 may be to FUNERAL DIRE director, page 3 should be filed by | 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) |
| 2 2 | 24. FUNERAL DIRECTOR 0 6 7 ADDRESS 256. REC'D BY REGISTRAR'S SIGNATURE |
| VR A15 (4) 15M 4-64 | Wit International Home 5732 Gener in iva mile 7 1967 (Charles Judge |
| 13141 4-04 | |



| , | 1 | MARYLAND STATE DEPARTMENT OF HEALTH | |
|------|--|--|--------------|
| - fe | FOR STATE | O5396 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 O5396 MEDICAL EXAMINER'S CERTIFICATE OF DEATH O5394 | , |
| | HEALTH DEPT. | 1. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceosed lived if institution Residence befor odmission) | 00) |
| | 5 6 8 ° | O COUNTY ON TAKEND MARYLAND MARYLAND MARYLAND | / |
| | 110 1 1 | b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) | |
| 4 | arth arth | 1/Axom A a Rx Syptionile | |
| | . If an farm farm | d NAME OF HOSPITAL OR INSTITUTION (II not in hospital, give street oddress) d SPRET ADDRESS e IS RESIL | ARM? |
| | | 3. NAME OF First Middle Lost 4 DATE Month Day Yes | NO 💢 |
| | | DECEASED A DE D | 67 |
| | Give do with the | S SEX 6 COLOR OR RACE 7 MARR ED A NEVER MARRIED 8 DATE OF BIRTH 9 AGE IN years IF UNDER 1 YEAR IF | - |
| | hours at them 18 Office | WINTE WIDOWED DIVORCED 7-17-18 69 YIS | win |
| | | 100 USUAL OCCUPATION (Give kind of work done during most of working life even if retired) 10b KIND OF BUSINESS OR 1. BIRTHPLACE (State or foreign country) 12 CIT ZEN OF WHAT COUNTRY? MACHINE CPERATER CONSTRUCTION OHIO | |
| | thin 24 miner's pages I pages I urs after | MACHINE CYERATER CONSTRUCTION OHO | |
| | within 24 h penci in th xaminer's 0 ile pages lo havis after | EDWARD KRITES MARY WECKESSER | |
| | ed with the land of the land o | IS. WAS DECEASED EVER IN J.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17 INFORMANT | |
| | executed in Medical permit. | (res. no. grynknown) (If yes give wor or dotes of service) 297031104 MARY G. KRITES SAME AS 2 | |
| | This certificate shauld be executed within 24 icate, writing the word 'penaing' in penci in be farwarded to the Chief Medical Examiner's I be used as a burial-transit permit. File pages removal, and in any event within 72 haurs after the contract of the | 18 CAUSE OF DEATH (Enter only one couse per line for (o) (b), and (c).) PART 1 DEATH WAS CAUSED BY. ONSET AND C | |
| | shauld be e a word 'per a the Chief ! burial-transit a any exent v | 4/201 IMMEDIATE (AJSE (o) DUE TO | - |
| | e shaul the wor ta the i burial- in any | Conditions, if ony, which gove) (b) | L |
| | the the single s | rise to immediate couse (a). stating the underlying couse { DUE TO | |
| | s certificate shauld e, writing the word farwarded ta the Cl used as a burial-tra | Rast. (c) | |
| | This certicate, writh be farward libe used removal, | PART II OTHER SIGNIF CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NAL DISEASE CONDITION GIVEN IN PART 1(D) 19 WAS AUTO PERFORM | DPSY IED? |
| | This be form | YES 200 EXTERNAL CAUSE WAS 200 DESCRIBE HOW INJURY OCCURRED (Enter nature of nury in Part Lor Port Lof item 18.) | NO Y |
| | INER: This shauld be shauld be files. 3 should be files. 3 should be fran, ar rem | E PRIMARY □ or CONTRIBUTING □ CAUSE OF DEATH | |
| | | 20c TIME OF INJURY Month, Doy, Year Hour a.m. p m 19 20d INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm factory, street, office bidg., etc.) (City or town) (County) (While at work of work of work) | (State) |
| | L EXA cecute Page far you R: Pag | 21 certify that I took charge of the remains described above, held on Autopsy , Inspection , Inquiry ond in my | opinion |
| 4 | MEDICAL EXAM bease execute it director Page 4 stained far your DIRECTOR: Page ta bunal, crema | deoth resulted from: Notural causes 🔀, Accident 🔲, Suicide 🔲, Homicide 🔲, Undetermined monner 🗌 | |
| | JTY MEDICA ity, please ereral director be retained RAL DIRECTO prior ta burn | ACTUAL AC | SIGNED |
| | Y, p y, p ral c AL I | SIGNATURE ASSISTANT MEDICAL EXAMINER | |
| | TO DEPUTY M necessary, p e the funeral di 5 may be reft TO FUNERAL D Health prior t | EXAMINER'S NAME TYPED TO SEE THE SECOND OF COUNTY) DEPUTY MEDICAL EXAMINER L Applicas (Single city, town, or county) | |
| | o o o o o o o o o o o o o o o o o o o | DEMOVAL (Constitution of the Lotter) | itote) |
| | - MK | BURYAL (Specify) APRIL 25,1967 FORT LINCOLN BLADENSBURG, MARYLAN. 24 FUNERAL D RECTOR 250, REG STRARS SIGNATURE | D |
| | VR A15ME (5) | SU III Ollandens Par Principal de la contra del la contra della contra | |
| | ۲. | W.W. CHAMBERS CO. HIVERDALE, MD APR 25 1967 VICUARIES JUST | |



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 haurs after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission e. COUNTY o. STATE b. COUNTY MARYLAND by m. Pages b. CITY OR TOWN (If outside comparate limits c. LENGTH OF STAY IN 1b outside corporate limits, write RURAL and give nearest town) c. CITY OR write RURAL and nure filled in t d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS IS RESIDENCE within YES NO # NAME OF DATE Month Year Dov carbor and completely DECEASED OF 196 (Type or print) DEATH IF UNDER 24 HRS 5. SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED DATE OF BIRTH AGE F JNDE YEAR remove Months Hours hdoy) Doys WIDOWED DIVORCED 12. CITIZEN OF WHAT 100 USUAL OCCUPATION (Give kind of work done during most of working life even if ret red) pleose signed by the ottending physicion buriol-transit permit. Then please achine 14. MOTHER S MAIDEN NAME 13 FATHER'S NAME INFORMANT TS. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service 50 INTERVAL BETWEEN CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c)) buriol-tronsit PART I DEATH WAS CAUSED BY ONSET AND DEATH CPTICEMIA IMMEDIATE CAUSE (o) DUE TO 3-4 DAYS LOCA lizer Conditions, if any, which gave rise to immediate couse (a), DUE TO stating the underlying couse the hos been lost. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) P NO Memia YES O FUNERAL DIRECTOR: After this certificate چ 20o ACCIDENT WAS UNDERLYING 20b, DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH detoched (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 2De. PLACE OF INJURY (Home, form, (City or town) (Stote) 20c. TIME OF INJURY Month, Doy, Year (County) Hour a.m. factory, street, office bldg., etc.) Not While of work ot work 21. I certify that (1) (this haspital) attended the deceased fram __, that (T) (we) last be retained should and that death accurred at 35-M, fram causes and an the date stated above saw the deceased alive an director, page 3 sho should be filed with 220. SIGNATURE 22b DATE SLØNED MED. DIRECTOR ATTENDING M.D. PHYS PHYS. 22d. ADDRESS VSICIAN MAME (Type 2803 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION. 23c NAME OF CEMETERY OR ERPMAFORY (County) (Stote) REMOVAL (Specify) 25b REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR 24. PONFRAL DIRECTOR VR A15 (4) 20 M 1/66 1967



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05398 CERTIFICATE OF DEATH (leoth. death. puo funerol : PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission o. COUNTY o. STATE b. COUNTY ely filled in by the function papers. Pages 1 c., within 72 hours ofter d MARYLAND MONTGOMERY MARYLAND 24 hours after MONTGOMERY b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

OLNEY c LENGTH OF STAY IN 1b c CITY DR TDWN (If outside corporate limits, write RURAL and give nearest town) 18 DAYS OLNEY d. NAME OF HDSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? MONTGOMERY GENERAL HOSPITAL YES NO X OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 3 NAME OF Middle First 4 DATE corbon Lost Month Doy Year ond completely DECEASED 1967 LADSON APR 1L 5 JACK ARTHUR (Type or print) event, DEATH S SPX 6. COLDR DR RACE IF UNDER 1 YEAR I IF UNDER 24 HRS 7. MARRIED B. DATE OF BIRTH 9. AGE (In years **NEVER MARRIED** remove lost birthdov) Months Dovs ond in only MALE WHITE WIDOWED DIVORCED 12/19/08 10a USUAL OCCUPATION (Give kind of work done 106 KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12 CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) INDUSTRY U.S.A VETER-INARIAN MARYLAND 13. FATHER S NAME 14. MOTHER'S MAIDEN NAME crematian, or removol, ottending phys JESSIE DAVIS THOMAS A. LADSON 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) (If yes give wor or dotes of service) 36 1:096 MEDICAL RECORDS 18 CAUSE OF DEATH (Enter only one couse per line for (o), (b); and (c).) the signed by the buriol-tronsit PART I. DEATH WAS CAUSED BY ONSALIANO DEATH IMMEDIATE CAUSE (o) Poge 4 may be retained by the hospital or attending physician. DUE TO burioi Conditions, if ony, which gove (b) rise to immediate cause (a). DUE TO stoting the underlying couse prior to l hos been os the PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NA. DISEASE CONDITION GIVEN IN PART 1(6) WAS AUTDPSY PERFORMED? for use YES 🗷 NO this certificate 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 1B.) 20o ACCIDENT WAS UNDERLYING OR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, 20f (City or town) (County) (Stote) Hour o.m. factory, street, office bldg., etc.) Not While ot wark of work **DIRECTOR:** After 21. 1 certify that (1) (this hospital) attended the deteored from that (I) (we) last saw the deceased alive an , and that death occurred at 2:45PM, from causes and an the date stated above. 22a. SIGNATURE 22h DIRECTOR M.D. page 22d. ADDRESS 22c PHYSICIAN'S TO FUNERAL director, po should be f C. H. LIGON. M.D. SANDY SPRING MEGACAN NAME (Type) 230 BURIAL, CREMATION, 23b. DATE THEREOF NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) REMDVAL (Specify) April 8 1967 Parklewn EGISTRAR'S SIGNAT 24. FUNERAL DIRECTOR VR A15 (4) 25M 1/67 Francis H. Barber Mid. Lavtonsville DATE

4.7

DIVISION OF STATISTICAL RESEARCH AND RECORDS --- BALTIMORE 1. MARYLAND **CERTIFICATE OF DEATH** PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a COUNTY **b. COUNTY** MARYLAND Montgomery Marvland death. CITY OR TOWN (If autside carporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) RURAL and give nearest tawn) (D.C. 20016 Bethesda Bethesda. d. NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS OR INSTITUTION 5608 Pollard Pollard Road ě NAME OF 4. DATE First Middle Month OF death. DEATH (Type or print) Frances Apri ê Lame 6 COLOR OR RACE MARRIED X NEVER MARRIED B. DATE OF BIRTH 9. AGE (In years last birthday) DIVORCED [Female WIDOWED | Mav papers aff 10a, USUAL OCCUPATION (Give kind af work dane) 10b, KIND OF BUSINESS OR INDUSTRY 11, BIRTHPLACE (State or foreign country) during most of working life, even if retired) Housewife Penna. and 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME John Pawling Bessie Dewling 17 INFORMANT 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 116. SOCIAL SECURITY NO. Address Edward F. Lane, 5608 Pollard Rd. no 1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Canditians, if any, which gave rise to immediate **DUE TO** cause (a), stating the underlying cause last PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19 WAS AUTOPSY PERFORMED? 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) 20c. TIME OF INJURY Month, 20e PLACE OF INJURY (Hame, farm, 20f, (City or town) Day, Year 20d. INJURY OCCURRED factory, street, office bldg., etc.) Haur a.m. While Not while at wark T at work T 120, 1967, that (1) (we) last 21. 1 certify that (1) (this haspital) attended the deceased fram... 20 1967, and that death accurred at ///M, from the causes and an the date stated above saw the deceased alive on _ 22a. SIGNATURE DIR page 3 should the State Board 22c. PHYSICIAN'S 22d ADDRESS NAME (Type) HOSPITAL FUNERAL E. Fitzgerald 23g BURIAL, CREMATION, 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City, tawn, ar county) Burial (Specify) Gate of Heaven Cem. Wheaton, Maryland, 10 ADDRESWashington, DD 250. REC'D BY MEGISTRA 24. FUNERAL DIRECTOR'S VR A15 (4) Wis.Ave.N.W. DATE 1SM 9/59

AND STATE DEPARTMENT OF HEALTH

e. IS RESIDENCE

ON A FARM?

YES NO TO

Year

19

Montgomery

Day

IF UNDER 1 YEAR IF UNDER 24 HRS

12. CITIZEN OF WHAT COUNTRY?

Hours

INTERVAL BETWEEN ONSET AND DEATH

YES NOXX

(State)

22b DATE SIGNED

(State)

Days

U.S.

(County)

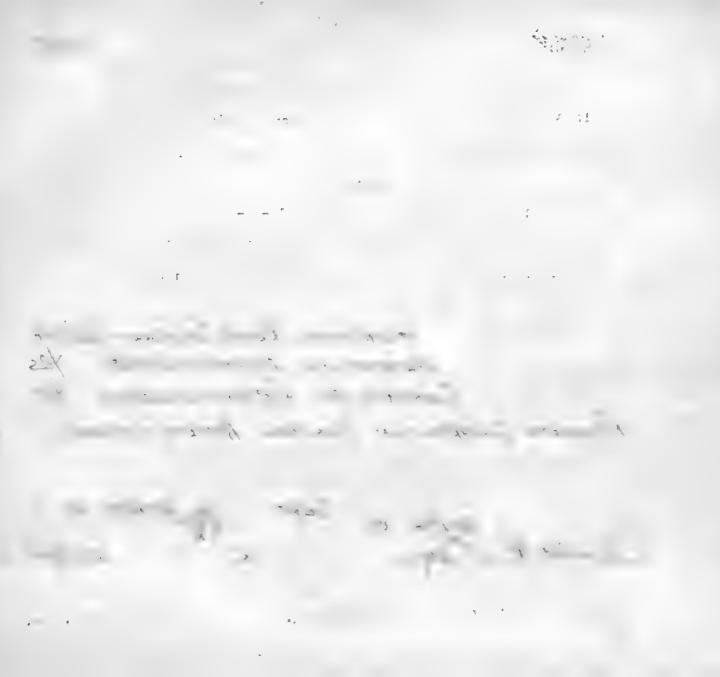
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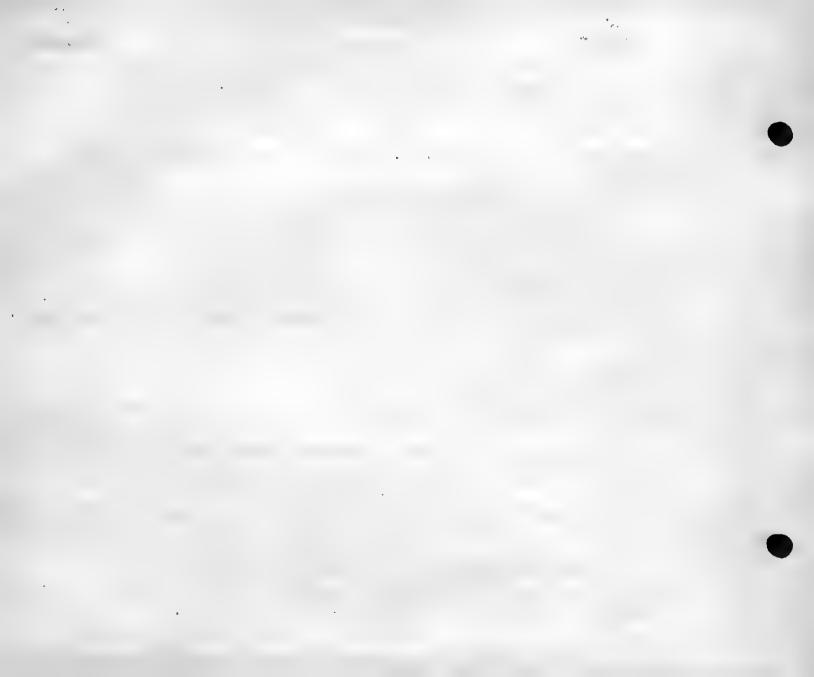


MARYLAND STATE DEPARTMENT OF HEALTH ISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MAR CERTIFICATE OF DEATH ath. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. COUNTY a. STATE b. COUNTY hours after Mont MARYLAND b. CITY OR TOWN (If outside corporate limits. c. CITY DR TDWN (If outside corporate limits, write RURAL end give nearest town) C. LENGTH OF STAY IN 1b papers. Page in 72 hours a write RURAL and give nearest town) 25 days WAShington filled in heaton d. NAME OF HDSPITAL OR INSTITUTION (If not in hospital, give street address) IS RESIDENCE ON A FARM? d. STREET ADDRESS 5t. N. W 4810 YES NO V S completely executed within 3. NAME DE First Middle DATE Last 4. Month Day Year DECEASED LANCHAR ELIZABETH (Type or print) DEATH AGE/(In years | IFUNDE | last birthday) | Months 5. SEX and cor 6. COLOR OR RACE 9 IF UNDER 1 YEAR IF UNDER 24 HRS DATE OF BIRTH 7. MARRIED NEVER MARRIED [**Oays** Hours Fe WIDOWED DIVORCED [] eattending physician are ermit. Then please reson, or moval, and in a 10a, USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT death certificate be during most of working life, even if retired) INDUSTRY COUNTRY? D.C. Sales NATURA Clerk Dept. Store 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME John Garrett Prenddile Elizabeth Gettner Marv 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. INFORMANT Address TO FUNERAL DIRECTOR: After this certificate has been signed by the atten director, page 3 should be detached for use as the burial-transit permit. should be filed with the State Dept. of Health prior to burial, cremation, or in the state burial state. (Yes, no, or unkown) (If yes give war or dates of service) Nursing Home Recorded Record 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ENSET AND DEATH PART I. DEATH WAS CAUSED BY: the hospital or attending physician. IMMEDIATE CAUSE (a) **OUE TO** Conditions, if any, which (b) gave rise to immediate DUE TO (a), stating underlying cause last. (c) CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY PERFORMED? YES NO TY 20a, ACCIDENT WAS UNDERLYING IT DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of Item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL TIME OF INJURY Month, Day, Year 20d, INJURY OCCURRED 20e, PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) factory, street, office bldg., etc.) Hour a,m. While Not While at work be retained by ATTENDING p.m. 19 at work 21. I certify that (I) (this hospital) attended the deceased from and that death occurred at a from the causes and on the date stated above saw the deceased alive on 22b. DATE SIGNED SIGNATURE ATTENDING Page 4 may 1 M.D. PHYS. DIRECTOR PHYS PHYSICIAN'S 22d ADDRESS NAME (Type) 23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) burial Va. Cem Arlington ington Nat FUNERAL OIRECTOR ADDRESS REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE VR A15 (4) 15M 4-64



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05401 CERTIFICATE OF DEATH The law requires that the death certificate be executed within 24 haurs after death funeral puo PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o. COUNTY o STATE **b** COUNTY Within 72 hours often MARYLAND b, CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Maryland Montgomery Poges the c. LENGTH OF STAY IN 1b c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest Town) ģ Olney Sandy Spring .<u>=</u> papers. d. NAME OF HOSP TAL OR INSTITUTION (If not in hospital, give street oddress) e IS RESIDENCE ON A FARM? NO YES Montgomery General Hospital 11871 Brooke Rd 3. NAME OF First Losi 4. DATE Month Year DECEASED (Type or print) 0F and in any event DEATH 67 Clars Lyman Latham and cample remaye to IF UNDER 1 YEAR S. SEX B. DATE OF BIRTH AGE (In years IF UNDER 24 HRS 6. COLOR OR RACE 7 MARRIED NEVER MARRIED lost birthdoy) Months Dovs Hours DIVORCED WIDOWED 12-28-79 87 α and 10o. USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12 CITIZEN OF WHAT please during most of working life, even if retired) INDUSTRY COUNTRY? Pennsylvanía TIS Unemployed 13 FATHER'S NAME 14 MOTHER'S MAIDEN NAME attending phys burial, cremation, ar remaval, Cornelius Amos Richardson 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17. INFORMANT Address permit. (Yes, no, or unknown) (If yes give wor or dates of service) ERMINAL RENAL SHUTDOWN-UREMY HAND DEATH 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c)) the signed by the barrial-transit PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) 6141. X DUE TO ETERIOLAR NEPHROSOLEROS Conditions, if any, which gove rise to immediate couse (a). DUE TO stoting the underlying couse Page 4 may be retained by the haspital or attending prior to HETERIOSCLEROSIS ENECAL120 SD WAS AUTOPSY PERFORMED? PART HOTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDITION GIVEN IN Health I certificate 20b. DESCRIBE HOW INJURY OCCURRED, (Enter noture of injury in Port I or Port If of item 18.) 20o ACCIDENT WAS UNDERLYING FT OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) State Dept. 3 TIME OF NJURY Month, Doy, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (C ty or town) (County) (Stote) WED! Hour o.m. Not While foctory, street, office bldg., etc.) 19 of work pe 21. I certify that (I) (this haspital) attended the deceased fram, 19 0 DIRECTOR: and that death accurred at W. fram causes and an the date stated above. saw the deceased alive **EIGNATURE** 22b DATE SIGNED director, page 3 should be filed v M.D DIRECTOR 22c PHYSICIAN'S 22d. ADDRESS O FUNERAL NAME (Type) 23d LOCATION (City or Town) 230 BURIAL CREMATION 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY (Cdunty) (Stote) Eulal 是仍私行品(A) 4/27/67 Counderport Gem Da 25b. REGISTRAR S SIGNATURE 24 EUNBRAL DIRECTOR ADDRESS 2So. REC'D BY REGISTRAR VR A15 (4) 25M 1/67



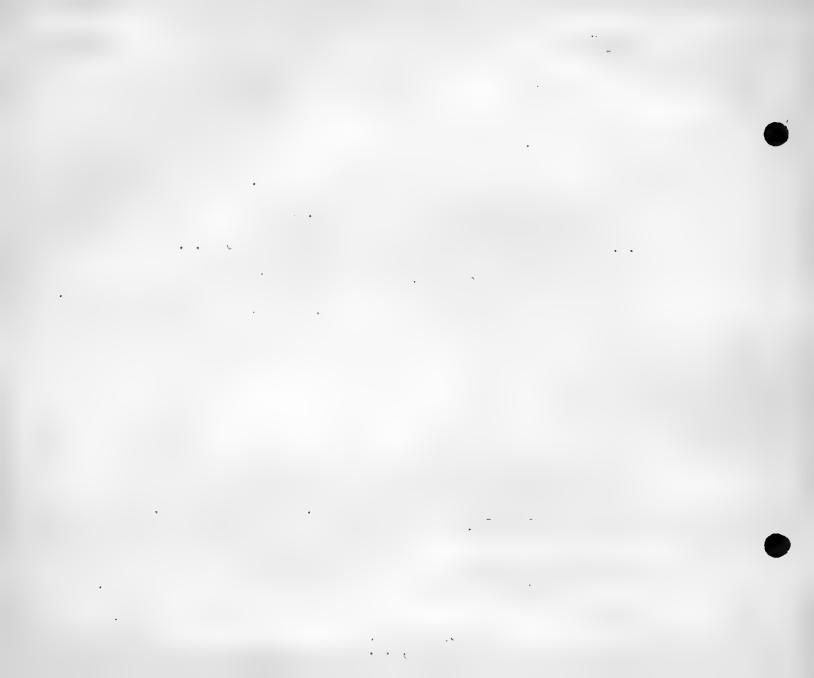


MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05403 CERTIFICATE OF DEATH PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a, STATE COUNTY trom ERU MARYLAND narylond MATCOMERU. CITY OR 70,WN (If autside corporate limits, write RUKAL and give nearest town) c. LENGTH OF SJAY IN 16 c CITY OR JOWN (If outside carparate limits, write RURA) and give nearest John) ⊑ d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM NAME OF Middle Year campletely carba DECEASED 1967 ABEL (Type or print) DEATH AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 7. MARRIED jast birthday) Manths WIDOWED DIVORCED 12 CITIZEN DE WHAT 10a, USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR IRTHPLACE (County & State, or fareign country) most of working life, even if retired) INDUSTRY crematian, ar removal, and mass. 16. SOCIAL SECURITY NO. 17 INFORMANT (Yes, no or unknown) (If yes give wor or dates at service) CAUSE OF DEATH (Ente signed by the burial-transit purial-tremative PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) AND DEATH DUE TO Canditians, if any, which gave rise to immediate cause (a), DUE TO stating the underlying couse be detached far use as the State Dept. af Health priar to 19. WAS AUTOPS PERFORMED? YES NO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) this certificate has NO 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 1 of Item 18) 20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (Crty or fown) (County) (State) factory, street, office bldg., etc.) Not While TO FUNERAL DIRECTOR: After 21 I certify that (I) (this hospital) attended the deceased fram ta_ saw the deceased olive an a and that death occurred at 1/45 DM, frage causes and on the date stated above 22a. SIGNATURE STAFF PHYS PHYS DIRECTOR director, page should be filed 22d ADDRESS 22c. PHYSICIAN'S NAME (Type) 23c NAME OF CEMETERY DR CREMATORY 23d LDCATION (City or Town) 23a. BURIAL CREMATION. 23b. DATE THEREOF (State) (County) REMOVAL (Specify)
Burial Parklawn Cemetery Rockville. Md Joseph G ADDRESS REC'D BY REGISTRAR VR A15 (4) 25M 1/67



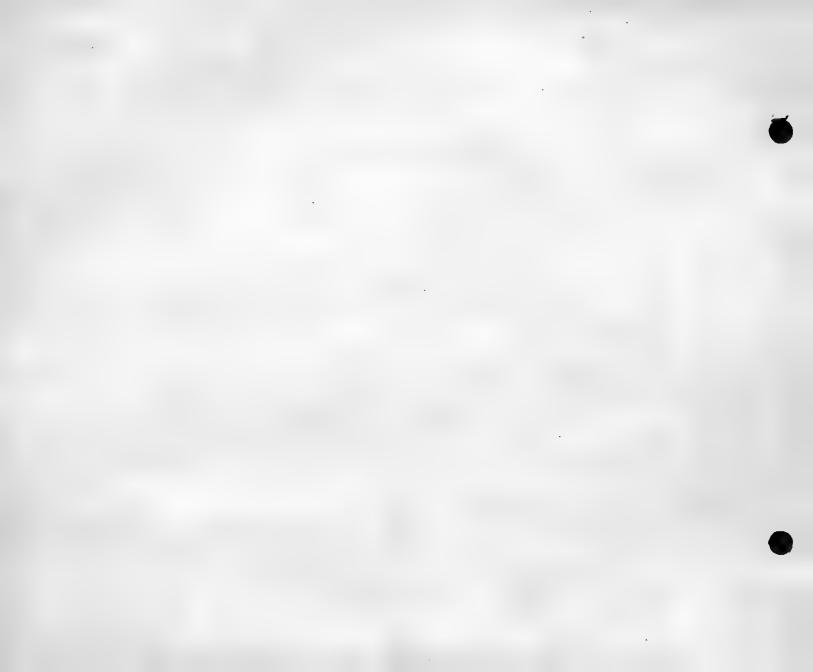


MARYLAND STATE DEPARTMENT OF HEALTH



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05406 CERTIFICATE OF DEATH death, PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death signed by the attending physician and campletely filled in by the funeral burial-transit permit. Then please remaye carbon papers. Pages 1 and USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PLACE OF DEATH o. STATE o. COUNTY b. COUNTY MONTGONDERY Moistgomeny hours after. MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring daus d. STREET ADDRESS IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) 8401 16th Street Randolph Hills Nursing Home YES NO X within DATE 3 NAME OF First Middle Lost Month Doy Year DECEASED OF Leather April. 5" Edwand John 19 event (Type or print) DEATH IF UNDER 1 YEAR IF UNDER 24 HRS. S. SEX AGE (In years 6. COLOR OR RACE 7. MARRIED NEVER MARRIED DATE OF BIRTH lost birthdoy) Months Hours white ma 10 in and WIDOWED DIVORCED 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT 100 USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR during most of working life, even if retired) COUNTRY? Brooklyn. New York 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Richard III. Teather Sarah Finnegan 17. INFORMANT IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give wor or dotes of service crematian, ar Grane S. Leather INTERVAL BETWEEN CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) attending physician. DUE TO burial. Conditions, if ony, which gove rise to immediate couse (o), DUE TO stoting the underlying couse prior to l TO FUNERAL DIRECTOR: After this certificate has been use as the lost. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(c) 19. WAS AUTOPS)
PERFORMED? NO V ARTERIUSCIEROSIS Page 4 may be retained by the haspital ar ģ 205. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 18.) 20o ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH be detached (IF FITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Year Hour o.m. foctory, street, office bldg , etc.) Not While ot work ot work 21. I certify that (I) (this haspital) attended the deceased fram. ., 1967, that (I) (we) last director, page 3 shauld should be filed with the 19 67, and that death accurred at 45 M, fram causes and an the date stated above saw the deceased alive an 22b. DATE SIGNED/ 22o. SIGNATURE ATTENDING MED. DIRECTOR STAFF PHYS. 22d. ADDRESS 22c. PHYSICIAN'S TO HOSPITAL NAME (Type) 23d. LOCATION (City or Town) (County) (Stote) 23o BURIAL CREMATION DATE THEREOF REMOVAL (Specify) Port Lincoln Crematory 94 Prince 100 tges 25b. REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR 24 FUNERAL DIRECTOR AT

MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S FOR STATE PLACE OF DEATH Roudence before admission) (Where deceased lived, if instituo COUNTY Ġ, b CITY OR TOWN (If autside sorporate c. LENGTH OF STAY IN 16 m is write RURAL and a.v write RURAL o IS RESIDENCE ON A FARM? YES NO NAME OF DATE OF DEATH DECEASED (Type or print) NEVER MARRIED Months Dovs Hours WIDOWED DIVORCED and in any event within 711 haurs after death 10b, KIND OF BUSINESS OR 12 CITIZEN OF WHAT Examiner s 13 FATHER pencil s certificate shauld be executed within ECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO INFORMANT Address permit. Chief Medical (Yes (pe, or unknown) (If yes give wor or dotes of service INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b) and (c)) **burial-transit** PART t. DEATH WAS CAUSED BY: Broncho Pneumonia IMMEDIATE CAUSE (o) writing the word DUE TO Inter Epinal Hemorrhage Conditions, fony, which gove rise to immediate couse (a), DUE TO stoting the underlying couse Accident GS be used remayal, PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) WAS AUTOPS' PERFORMED? 20o. EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Port I or Port II of item 18.) 3 should PRIMARY SLOT CONTRIBUTING CAUSE OF DEATH cremation, ar Impal Hard causing MEDICAL 20d INJURY OCCURRED (City or town). (County) (Stote) 20c TIME OF INJURY Month, Doy, Year Not While A factory street office bldg etc.) may be retained for your FUNERAL DIRECTOR: Page Se17209 -Md MINT-21 1 certify that I took charge of the remains described above, held an Autapsy (X), Inspection X Inquiry X and in my opinian Natural causes . Accident X Undetermined manner death resulted fram-Suicide Hamicide the funeral directal CHIEF MED CAL EXAMINER ACTUAL 22. DATE SIGNED SIGNATURE DEPUTY MEDICAL EXAMINER **EXAM NER'S** Health NAME (Type) Address (Street city, town or county) NAME OF CEMETERY OR CREMATOR 23d LOCATION (GIY of Town) 230 BURIAL CREMATION DATE THEREOF 0 FUNERAL DIRECTOR VR A15ME 151

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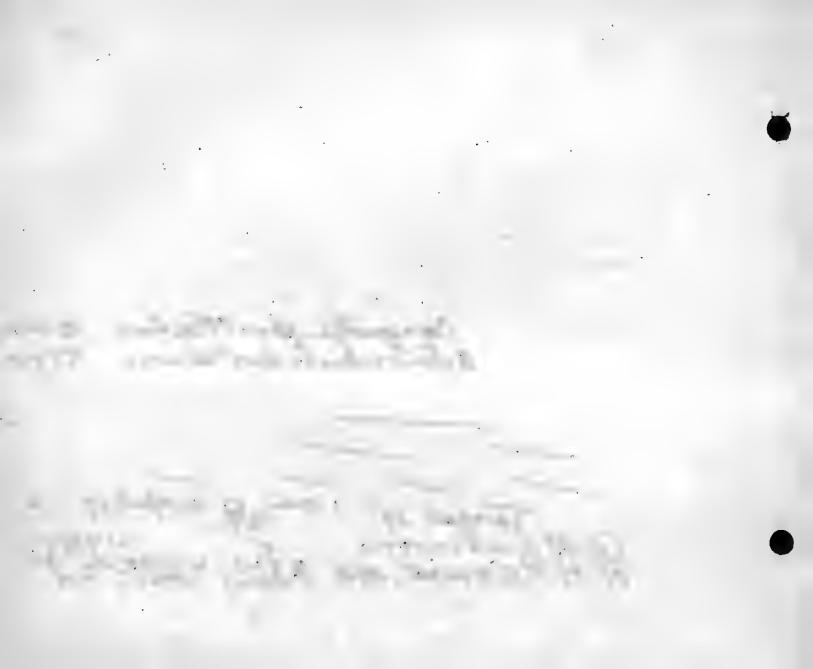
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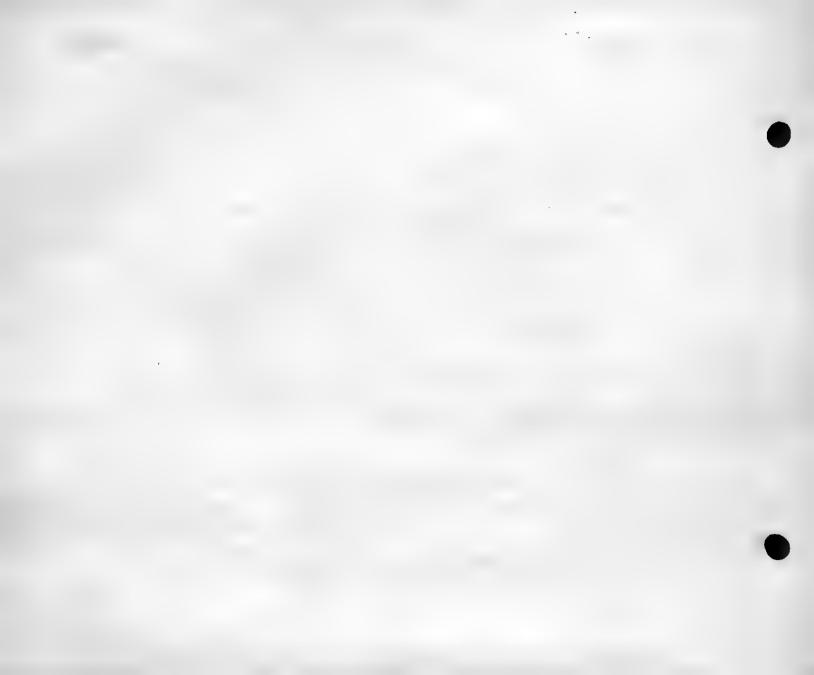
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH death. and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. CDUNTY b COUNTY after MARYLAND b. CITY OR TOWN (if outside corporate limits. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH DF STAY IN 1b Write RURAL and give nearest town) hours d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? fille pape ND within completely carbon NAME OF DATE Middle 4. First Last Day DECEASED event, (Type or print) DEATH 19 6. COLOR OR RACE 7. MARRIED DATE OF BIRTH AGE (My years | IFUNDER 1 YEAR IFUNDER 24 HRS last birthday) Months | Days | Hours | Min. remove 9. 8. NEVER MARRIED Months Hours and in any WIDOWED [DIVDRCED [nding physician a Then please re removal, and in a 10a, USUAL OCCUPATION (Give kind of work done) 10b, KIND OF BUSINESS DR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT death certificate be during most of working life, even If retired) COUNTRY? NEBRASICA CORATE 14. MOTHER'S MAIDEN NAME AUGUSTA 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT ed by the attend trans.t permit. cremation, or r Address (Yes, no, or unkown) [(If yes give war or dates of service) RIDGEL SAME 18. CAUSE OF DEATH [Enter only one cause per line for (a). requires that the been signed the burial-trans. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, If any, which gave rise to immediate 計さ DUE TD cause (a), stating the underlying cause last, SS 19. WAS AUTDPSY PART II. DTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMED? NO YES 20a. ACCIDENT WAS UNDERLYING TO OR CONTRIBUTING TO CAUSE OF DEATH-(IF EITHER, NOTIFY MEDICAL EXAMINER) PHYSICIAN: 20b. DESCRIBE HOW INJURY DCCURRED. (Enter nature of injury in Part 1 or Part 11 of Item 18.) detached for the Dept. of 1 this (County) (State) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE DF INJURY (Home, farm, 20f. (City or town) factory, street_office bldg., etc.) Hour a.m. White Not White After at work at work O 21. I certify that (i) (this boottal) attended the deceased from DIRECTOR: age 3 should filed with the and that death occurred at on the date stated above. saw the deceased alive on M. from the causes and 22a. SIGNATURE MED STAFF PHYS. DIRECTOR 13 HOSPITAL FUNERAL 22c. director, p Page 4 CREMATION, 23b. NAME DE CEMETERY OR CREMATORY ₹3d. LOCATION (City, town or county) (State) BURIAL DATE 23c. 2 REGISTRAR'S SIGNATURE FUNERAL DIRECTOR **ADDRESS** 25b. VR A15 (4) 20M 1/65

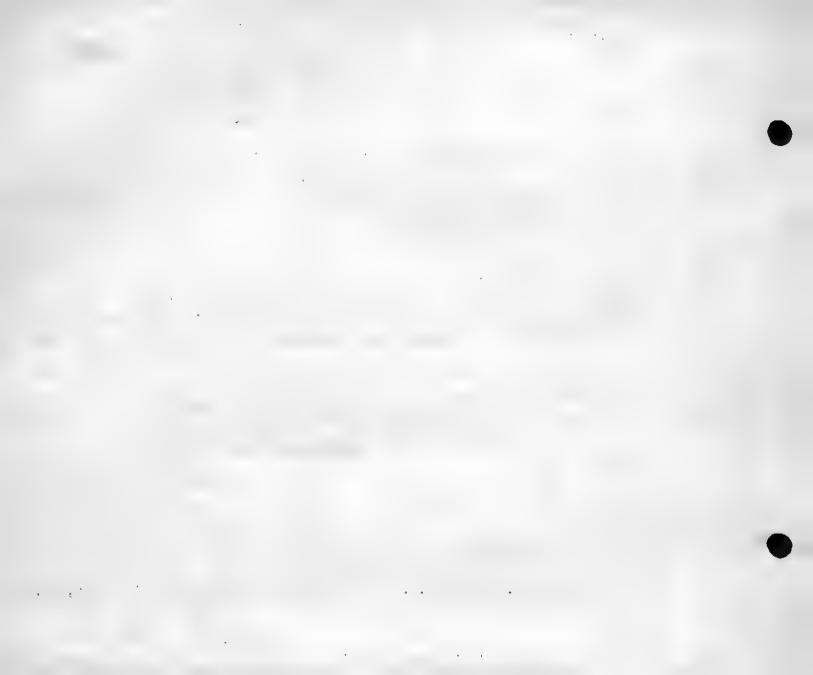


MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05409 CERTIFICATE OF DEATH The law requires that the death certificate be executed within 24 hours after death PLACE OF DEATH ond 2 USUAL RESIDENCE (Where degeosed liver, if institution, Residence before admission o. COUNTY b. COUNTY remove carbon popers. Pages 1 in ony event, within 72 hours after MARYLAND b CITY OR TOWN (If outside corporate limits C. LENGTH OF STAY IN 16 c. CITY OR TOWN (If purside corporate limits, write RURAL and give nearest town write RURAL and give nearest town) ndse Mase .⊑ d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS ON A FARM? filled ERRACE I EARINGE NO X 4 DATE OF DEATH 3. NAME OF Middle Month Doy Year DECEASED (Type or pant) S SEX AGE (In years IF UNDER I YEAR IF JNDER 24 HRS. 6 COLOR OR RACE 7. MARRIED NEVER MARRIED DATE OF BIRTH Months lost buthday) Doys Hours WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT MERICA INDUSTRY USSIA 13. FATHER'S NAMI 14. MOTHER'S MAIDEN NAME RockLin 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or michawn) (If yes give war or dates of service) ō cremation, CAUSE OF DEATH (Enter only one cause per line for (d)) (b), and (c).) INTERVAL BETWEEN signed by the buriol-tronsit PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (o) DUE TO buriol, Conditions, if ony, which gove rise to immediate couse (a), DUE TO stoting the underlying couse as the prior to last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 19. WAS AUTOPSY PERFORMED? USe State Dept. of Health Bronch NO X YES certificote ē 200 ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Port II of Item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e PLACE OF INJURY (Home, form, (City or town) (Stote) 20c. TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED (County) Hour o.m. foctory, street, office bldg., etc.) Not While of work of work 2). I certify that (I) (this haspital) attended the deceased fram sort up = r 19600 10/1/11/L . 1967, that (I) (see) .ast 1967, and that death accurred at 4:100 M, from causes and an the date stated above. saw the deceased alive on April 22 FUNERAL DIRECTOR: 22o. SIGNATURE DATE SIGNED DIRECTOR M.D PHYS. PHYS. director, page should be filed 22d ADDRESS 22c. PHYSICIAN S Page 4 may ROWELL 2025EVE BURHAL CREMATION 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) DATE THEREOF (County) REMOVAL (Specify) Both Sprac adotto 24 FUNERAL DIRECTOR **ADDRESS** REC'D BY REGISTRAR REGISTRAR'S SIGNATURE VR A15 (II) mannor



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05410 CERTIFICATE OF DEATH death, requires that the death certificate be executed within 24 haurs after death filled in by the funeral papers. Pages 1 and 2 thin 72 haurs after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution; Residence before admission o. COUNTY o. STATE b. COUNTY Montgomery Virginia MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 3b Days Norfolk d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e IS RESIDENCE ON A FARM? d. STREET ADDRESS The Clinical Center, Bethesda, Maryland 1852 Ogden Street YES NO TY 3 NAME OF Middle 4 DATE First Lost Month Doy Year DECEASED (Type or print) Donnie Mae Lewis April 67 DEATH IF UNDER 24 HRS. 9. AGE (In years S. SEX 6. COLOR OR RACE DATE OF BIRTH 7 MARRIED NEVER MARRIED gue lost birthdoy) Months Doys Hours ar remaval, and in any WIDOWED TO DIVORCED 12 April 1909 Female Negro 100 USUA OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewile 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT COUNTRY? signed by the attending physician (burial-transit permit. Then please INDUSTRY Georgia IISA 14 MOTHER'S MAIDEN NAME 13 FATHER'S NAME John W. Cannon Mattie Belle Hardrick 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT The Medical Records (Yes, no, or unknown) (If yes give wor or dotes of service) Not Available The Clinical Center, Bethesda, Maryland INTERVAL BETWEEN 18 CAUSE OF DEATH (Enter on y one couse per line for (o), (b), and (t) PART I DEATH WAS CAUSED BY: Intraperitoneal hemmorrhage IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gave Peritonitis 48 hours rise to immediate couse (o), DUE TO stating the underlying couse as the has been Radiation recurrent carcinoma of cervix 1 year 19. WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) CERTIFICATION YESXIX NO TO FUNERAL DIRECTOR: After this certificate director, page 3 shauld be detached far us shauld be filed with the State Dept. af Healt 20o, ACCIDENT WAS UNDERLYING 205 DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Month, Doy, Yeor 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour o.m. Not While foctory, street, office bldg , etc.) of work 21. 1 certify that (1) (this haspital) attended the deceased from 7 March saw the deceased alive on 5 April 19 67, and that deoth occurred of 1:00 M, from causes and on the date stated above. 22b. DATE SIGNED 22o. SIGNATURE ATTENDING M.D. DIRECTOR PHYS. 6 April 1967 22d. ADDRES9The Clinical Center, National 22c. PHYSICIAN'S NAME (Type) Frank C. Sparks, M.D. Institutes of Health, Bethesda, Md 23r. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) BURIAL, CREMATION, REMOVAL (Specify) DATE THEREOF (Stote) Norfolk, 4/8/67 25h REGISTRAR'S SIGNATURE **ADDRESS** 24_FUNERAL DIRECTOR REC'D BY REGISTRAR Faneral Home, Inc. Island Ave., N. W. Frazier's Rhode VR A15 (4) Wash., D. C. 20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF PLACE OF DEATH USUAL RESIDENCE (Where deceased I ved, if institution Residence before admission Poge 0 deoth MARYIAND delay C LENGTH OF STAY IN 16 Wr te, RLRAL puo PM3 after (UTION (If nat in haspital, give street address) d STREET ADDRESS IS RES DENCE Del Office along with form ON A FARMS a e e Give Poges 7 2LM0 24 hours after deoth NAME QUATY Middle Last DATE Year OF within (Type or print) = DEATH SEX COLOR OR RACE 7 MARRIED NEVER MARRIED DATE OF BRIH F JNDFR 1 YEAR IF JNDER 24 HRS wrihday) Months Haurs WIDOWED DIVORCED event Ċ pup OCCUPATION (Give kind of work done 10b K ND OF BUSINESS OR 11 RIRTHPLACE (State or foreign country) 12 CITIZEN OF WHAT INDUSTRY any ⊆ **Exominer's** 13 FATHER'S NAME This certificate shauld be executed within 14. MOTHER'S MAIDEN NAME .⊑ ir cinia-Burkhalter <u>الله</u> pup AS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT Address Chief Medical permit. removol (Yes, no, or unknown) (f yes give wor or dotes of service) Home Records CAUSE OF DEATH (Enter only one cause per tipe for (a), (b), and (c)) ONSET AND DEATH burial-transit PART I. DEATH WAS CAUSED BY cremation, or IMMEDIATE CAUSE (6) word DUE TO Conditions, if only, which gove rise to immediate couse (o), DUE TO 0 stoting the underlying cause last. 0.5 burial, paso 19 WAS ALTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NA. DISEASE CONDITION GIVEN IN PART 1(a) YES NO certificote designated agent, prior to g Pe 20g EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part L or Port If of item 18.) pluods PRIMARY I or CONTRIBUTING I should CAUSE OF DEATH 20c. TIME OF INJURY Manth, Day, Year 20d INJURY OCCURRED 20e, PLACE OF NJURY (Hame, form, (City or town) (County) (State) Raur a.m. foctory, street, affice bldg., etc.) While Not While FUNERAL DIRECTOR: Page at wark 21. I certify that I taok charge of the remains described above, held an Autopsy [Inspection and in my opinion death resulted from: Natural causes Ascident Suicide Homicide Undetermined monner be retained CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED SIGNATURE the funerol O DEPUTY 5 **EXAMINER'S** Heolth . Address (Street, city may BURIAL, CREMATION 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Youn) (County) (Stote) 0 REMOVAL (Specify)
Durial Rock Greek Cemetery Washington. 18/67 Commany 24 FUNERAL DIRECTOR Hines 25a REC D BY REGISTRAR 2Sb REGISTRAR'S SIGNATURE VR A15ME (5) Ochenelas Judaz Wash

6M 1/66



| _23. | 1 | MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1. MARYLAND | 410 |
|------|--|--|--------------------------------|
| A.C. | | 15412 Thom #8 Pt 1 - #G287) CERTIFICATE OF DEATH SERECK ELLWOOD LIV | 7 F7 FV |
| | after death, the funeral ges and and after death, after death | 1. PLACE OF DEATH a. COUNTY MARYLAND b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (if outside corporate limits, write RURAL and give | efore admissi |
| | 24 hours afte filled in by the papers. Pages in 72 hours aft | TAKONG FARK MINUTES SILVER SPRING d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS O 0 6. | IS RESIDEN |
| | competely competely event, with | 3. NAME OF DECEASED (Type or print) 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years IF UNDER 17 EAR) 1835 DIRTH | Year 1967 |
| | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR UNDUSTRY LUMBER CONT PLUMBING HARTERS NAME 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF COUNTRY? HARTERS NAME 14. MOTHER'S MAIDEN NAME | |
| | th certification in the certification in the certification of remo | SACOB LIVEZEV 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or pulkown) (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Address WILL. N. G. L. | |
| | requires ding phy been sig the buri r to buri | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSC LEROTIC HEART DISEASE ONSET (Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (C) ONSET ONSET ONSET (C) | AL BETWEE |
| | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUTNOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. W YES 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 4. CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | VAS AUTOPS PERFORMED? NO |
| | JING PHYSIC d by the hos After this c d be detache State Dept. | 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) factory, street, office bldg., etc.) While Not While at work at work | (State) |
| | D HOSPITAL OR ATTENDING PHYSICIAN: Page 4 may be retained by the hospital FUNERAL OIRECTOR: After this certific director, page 3 should be detached for should be filed with the State Dept. of He | saw the deceased affive on 46 1967, and that death occurred at 3 PM, from the causes and on the date of the signature deceased affive on 46 1967, and that death occurred at 3 PM, from the causes and on the date of the signature deceased affive on 46 1967, and that death occurred at 3 PM, from the causes and on the date of the signature deceased affive on 46 1967, and that death occurred at 3 PM, from the causes and on the date of the signature deceased affive on 46 1967, and that death occurred at 3 PM, from the causes and on the date of the signature deceased affive on 46 1967, and that death occurred at 3 PM, from the causes and on the date of the signature deceased affive on 46 1967, and that death occurred at 3 PM, from the causes and on the date of the signature deceased affive on 46 1967, and that death occurred at 3 PM, from the causes and on the date of the signature deceased affive of the signature deceased affirm a signature deceas | stated abo |
| | TO HOSPITAL OR Page 4 may be TO FUNERAL OIR director, page should be filed | 232. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) BEMOVAL (Specify) BURIAL (Sp | (State) M.S. |
| | VR AIS (4) 20M 1/65 | TAKOMA PARK FUNERALI 254 CONNUL DAKER 10 1967 PULLED | 0 |

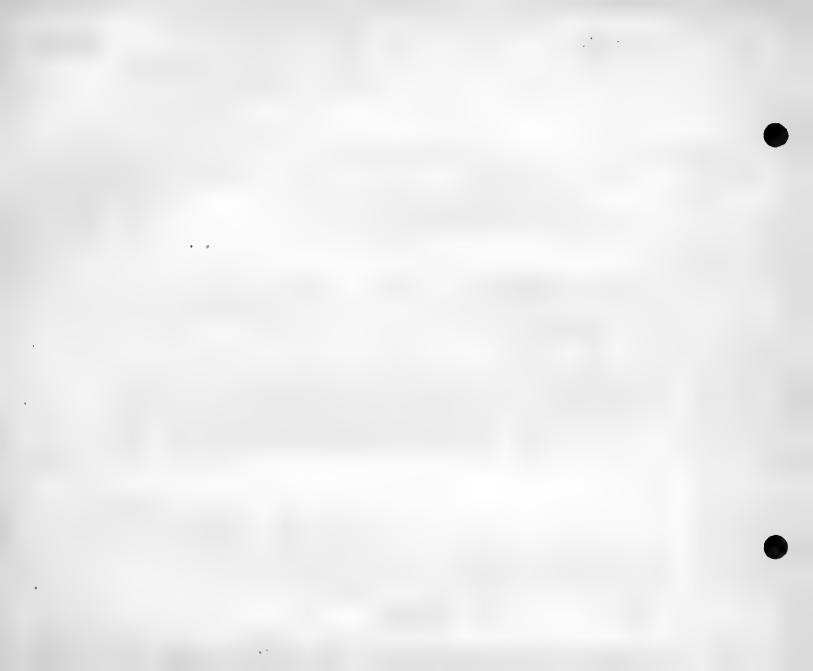


MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 35413 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR 5 PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o. COUNTY Montgemery o STATE b. COUNTY neven: into certificate, writing the ward "pending" in pancil in Item 18. Give Pages 1, 2, and 3 to salauld be forwarded to the Ch et Medical Examiner's Office along with farm PM3. Page MARYLAND c LENGTH OF STAY IN 16 b CITY OR TOWN (If outside corparate imits (If outside corporate I mits, write RJRAL and give nearest town) d NAME OF HOSPITAL OR INSTIT d STREET ADDRESS e IS RESIDENCE ON A FARM? (If not in hospital, give street address) NO X NAME OF y ear DECEASED OF DEATH Locke avis 1967 S. SEX 6 COLOR OR RACE 7. MARRIED NEVER MARRIED DATE OF BIRTH AGE (In years .F JNDER 1 YEAR IF UNDER 24 HR lost birthday) Months Hours JULY 22.1 WIDOWED DIVORCED 100 USUAL OCCUPATION (Give kind of work done 11 BIRTHPLACE (State or foreign country) 10b KIND OF BUSINESS OR 12. CITIZEN OF WHAT during most of working life, even if retired) COUNTRY? Naval Hospit. Penna. Research Assistant 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME GeorgexRixixx Elizabeth Maynard 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17 INFORMANT 16 SOCIAL SECURITY NO Address (Yes, no, or unknown) [(If yes give wor or dates of service) Lockwood Drive 153-28-2106 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c),) PART I DEATH WAS CAUSED BY SONSET AND DEATH in any event Soun Shot Wound of IMMEDIATE CAUSE (a) DUE TO Salf-inflected. Conditions, if any, which gave nse to immediate couse (a), DUF TO stating the underlying cause last. 19 WAS AUTOPSY PERFORMED? YES NO cremation, or removal, PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 20o EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 3 should PRIMARY LY OF CONTR BUTING CAUSE OF DEATH Head with 32 col. Pistol MEDICAL 20e. PLACE OF INJURY (Home, farm, 20c TiME OF INJURY Month, Day, Year (City or fown) (County) (Stote) Not While foctory, street, office bldg , etc) While moy Re retoined for yaur FUNERAL DIRECTOR: Poge of work Chery Chase Ment -Md Home 21 I certify that I took charge of the remains described above, held on Autopsy 5 moy le retoined for to FUNERAL DIRECTOR:P Health prior to buriol, a Inspection ... Inquiry X. and in my opinion Natural couses . Accident . Suicide . Homicide Undetermined monner deoth resulted from. the funeral director CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE O DEPUTY DEPUTY MED CAL EXAMINER 2 Setherda. Georgetown Rd. Address (Street, city, town, or county) NAME (Type) 23c NAME OF CEMETERY OR CREMATORY 23a. BURIAL, CREMATION, 23b DATE THEREOF 23d LOCATION (City or Town) (State) REMOVAL (Specify) Lincoln Crematory Prince Georges 250 REC'D BY REGISTRAR 756 REGISTRAR S SIGNATURE VR A 15ME (5 ocharles 6M 1/67 Pumphrey





MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05413 05415 CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. COUNTY **b** COUNTY Montgomerv Maryland MARYLAND Prince Georges b. CITY OR TOWN (If autside carparate Fmits. c. LENGTH OF STAY IN 16 **TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours aft Page 4 may be retained by the hospital or ottending physician. c CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) write RURAL and give negrest tawn)
Bethesda 87 days Greenbelt d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e IS RESIDENCE ON A FARM? The Clinical Center, Bethesda, Maryland Ridge Road YES NO ---NAME OF last 4 DATE Month Day and completely DECEASED Keith Andreas (Type or print) Longas April 19 67 DEATH S. SEX NEVER MARRIED AGF (In years 6 COLOR OR RACE 7. MARRIED B. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. lost birthday) Months Hours DIVORCED 8 June 1960 WIDOWED Male White 10g JSUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State or foreign country) 12 CITIZEN OF WHAT physician (ien pleose during most of working life, even if retired) INDUSTRY **COUNTRY?** USA Washington, D.C. Student None 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Leona Blackman Socrates A. Longas 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war ar dates of service) 16 SOCIAL SECURITY NO 17 INFORMANTThe Medical Recordidress The Clinical Center, Bethesda, Maryland None IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) INTERVAL BETWEEN signed by the burial-tronsit p PART I. DEATH WAS CAUSED BY: ONSET AND DEATH IMMEDIATE CAUSE (a) Cardiac Failure. Refractory DUF TO Conditions, if any, which gove it Suspected Drug Toxicity 2 Wks. rise to immediate couse (a). DUF TO stating the underlying cause TO FUNERAL DIRECTOR: After this certificate has been 35 Yrs. ()_Acute Lymphocytic Leukemia WAS AUTOPS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBLTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMED? YES TOT NO F 20a ACC DENT WAS UNDERLYING [20b DESCRIBE HOW INJURY OCCURRED (Enter nature of in any in Part I or Part 11 of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Manth, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame farm. 20f. (City or town) (County) (State) factory, street, affice bldg., etc.) Not While at work at work 21. I certify that (A) (this haspital) attended the deceased fram January 30, 1967, to April 27, 1967, that (N) (we) last saw the deceased alive an 27 April 1967, and that death accurred at 7:05 M, fram causes and an the date stated above 22a SIGNATURE 22b. DATE SIGNED ATTENDING STAFF X 28 April 1967 DIRECTOR M.D 22d. ADDRESSThe Clinical Center, National 22c. PHYSICIAN'S NAME (Type) Institutes of Health, Bethesda, Md. Herbert E. Kann. Jr 23c NAME OF CEMETERY OR CREMATORY 23b. DATE THEREOF 230 BURIAL, CREMATION, 23d. LOCATION (City or Tawn) (County) (State) BUPIAL (Specify) Hillside, Maryland Chesed Shel Emmes ADDRESS 3501-14th | 250 REC'D BY REGISTRAR 2Sb REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR Ochanles Bernard Danzansky & Sons St., N.W. Wash. D. GMAY 2 1967 25M 1/67



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05416 CERTIFICATE OF DEATH ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death 2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) PLACE OF DEATH a. COUNTY a. STATE b. COUNTY < MARYLAND C LENGTH OF STAY IN 16 outside corporate limits, write RURAL and give negrest town) CITY OR TOWN (If outside corporate limits t, CITY OR TOWN d NAME OF HOSPITAL OR INSTITUTION (f not in hospital, give street address) d STREET ADDRESS IS RESIDENCE ON A FARM? and completely filled in Temaye carban papers. YES NO NAME OF Middle DECEASED
(Type or print) DEATH 9. AGE (In years IF UNDER 1 YEAR SEX NEVER MARRIED lost birthday) Months Days Hours WIDOWED DIVORCED 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 10a HSUAL OCCUPATION (Give kind of work done COUNTRY? during most of working life, even if retired) IND JSTRY physicián ien please Interior Decorato Retired 13 FATHER'S NAME ar_remaya 17. INFORMANT Wife Address Same as IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no, ar unknown) (If yes give war ar dates of service) Item 578-03-4015 Marjorie H.Loveless cremation, INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c)) ONSET AND DEATH burial-transit PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) signed by DUE TO burial, i Canditions, if any, which gove rise to immediate cause (a), DUE TO stoting the underlying couse O FUNERAL DIRECTOR: After this certificate has been Health prior to last. 19. WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) NO be retained by the haspital ar 205. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Port II of item 18.) 20g ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH State Dept. of detached (IF EITHER, NOTIFY MEDICAL EXAMINER) (City or town) (State) 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Hame, farm, (County) 20c. TIME OF INJURY Month, Day, Year factory, street, office blda., etc.) Nat While at wark 1967, that (I) (we) last 2]. I certify that (1) (this hospital) attended the deceased from with the deoth occurred at Z 5PM, from causes and on the date stoted above ond that saw the deceased alive on_ 22d. SIGNATURE 22b. DATE SIGNED MED. DIRECTOR M.D. PHYS PHYS director, page should be filed 22d. ADDRESS PHYSICIAN'S NAME (Type) 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION 23b. DATE THEREOF (County) (State) REMOVAL (Specify)
Burial 4-21-67 Mt. Olivet Cemetery Washington. 2Sq REC'D BY REGISTRAR 2Sb REGISTRAR'S SIGNATURE ADDRESS PUMPHREY, Bethesda, Maryland VR A15 (4) 20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05415 CERTIFICATE OF DEATH 05417 The law requires that the death certificate be executed within 24 haurs after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. COUNTY o. STATE **b** COUNTY Montgomery MARYLAND Maryland Montgomery c. LENGTH OF STAY IN 16 c CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town b CITY OR TOWN (If outside carparate limits, write RURAL and give nearest lawn) Kenwood Kenwood 16 years d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? 5316 Oakland Road 5316 Oakland Road NO X NAME OF Middle 4. DATE Last Month Day Year DECEASED FitzGerald Anthony Lucas complete 1967 April (Type or print) DEATH S SEX IF UNDER 1 YEAR IF UNDER 24 HRS 6 COLOR OR RACE 8 DATE OF BIRTH 9 AGE (In years 7 MARRIED NEVER MARRIED last birthday) Manths Haurs 7-21-1889 WIDOWED DIVORCED White Male 10a USUA, OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired) Engineer U.S.A. Washington. D.C. 14 MOTHER'S MAIDEN NAME 13. FATHER'S NAME cremation, or remayal, Caroline FitgGerald Anthony F. Lucas 17 INFORMANT 15 WAS DECEASED EVER IN U.S ARMED FORCES? 16. SOCIAL SECURITY NO (Yes, no or unknown) (If yes a ve wor ac dates of service) 577-36-8292-A/ Ruth H. Lucas, See Item No.2. 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY INTERVAL BETWEEN ONSET AND DEATH f prostate gland IMMEDIATE CAUSE (a) DUE TO Conditions, if ony, which gave rise to immediate cause (a), DUE TO stating the underlying cause O HOSPITAL OR ATTENDING PHYSICIAN: The law re Page 4 may be retained by the hospital ar attending has been PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19 WAS AUTOPS'
PERFORMED? arteriosclerotic cardiac diseas YES NO E 20b DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of item 18.) 20a ACCIDENT WAS JNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame, form, (City or town) (State) 20c TIME OF INJURY Month, Doy, Year (County) factory, street, affice bldg., etc.) Not While at wark While at work 2). I certify that (1) (this hospital) attended the deceased from February 1, 1967, to april 6, 1967, that (1) (we) last saw the deceased alive on Mark 29 1967, and that deoth occurred at 250 M, from causes and on the date stated above. 22b. DATE SIGNED 22a. SIGNATURE Wound. Eger DIRECTOR director, page 3 should be filed v M.D. 22d ADDRESS 22c PHYSICIAN'S D FUNERAL 1801 NAME (Type) 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Tawn) 23b DATE THEREOF 23a. BURIAL, CREMATION, REMOVAL (Specify) Rock Creek Cemetery | Wash 4-8-1967 Washington VR A15 (4) Joseph Gawler's Sons, Inc. Wash, D.C.



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH death 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY o STATE b. COUNTY requires that the death certificate be executed within 24 hours after ont overy MARYLAND Tontror ray b. CITY OR TOWN (If ourside corporate limits. c LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) days Silver Spring Takoma Park d. NAME OF HOSPITAL OR UNSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS IS RESIDENCE ON A FARM? filled i Sanitarium 1707 Cody Drive YES NO M Washin, ton 900000000 3. NAME OF Middie Inst 4 DATE Dov Year DECEASED (Type or print) 1967 John MacDermott DEATH S. SEX 6. COLOR OR RACE 7. MARRIED 8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. NEVER MARRIED lost birthdov) Months Hours WIDOWED DIVORCED male 5_11_87 100 USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT physician of and ir during most of working life, even if retired) COUNTRY? INDUSTRY Denistry Tiental Surgeon Massachusetts 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME John T. NacDermott Katherine Nowood IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. INFORMANT permit. (Yes, no, or unknown). If If yes give wor or dates of service ь Mac Dermott Len K crematian, 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c), signed by the burial-transit p PART I. DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o' DUE TO Conditions, if ony, which gove rise to immediate couse (a). DUE TO as been a sthe being to be storing the underlying couse last. has 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT REVATED TO THE TERMINAL DISEASE CONDITION/GIVEN IN PART 1(a). far use Healthy NO certificate 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18 200 ACCIDENT WAS UNDERLYING [1] OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) tached Pept. c 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (Stote) ō Hour 'o.m. factory, street, office bldg., etc.) Not While of work at work 21. I certify that (1) (this haspital) attended the deceased fram Hill be . to Ce 7.1967, that (1) (we) last be retained saw the deceased alive an lateral 36 1967, and that death accurred at M. from causes and an the date stated above. O FUNERAL DIRECTOR: 220. SIGNATURE DIRECTOR PHYS directar, page should be filed 22c. PHYSICIAN'S 22d NAME (Type) 230 BURIAL CREMATION. 23b DATE THEREOF NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town (Stote) REMOVAL (Specify) 2So. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE Warner ? Pumpirteu



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 95413 CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o. COUNTY b. COUNTY_ MARYLAND b CITY OR TOWN (If auts.de corporate limits c LENGTH OF STAY IN 16 CITY OR TOWN (If OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs aft existe corporate limits, write RURAL and give decrest town) write RURAL and UNSTITUTION (If not in haspital, give street address). d. STREET ADDRESS YES NAME OF Middle DATE DECEASED (Type or print) DEATH AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS NEVER MARRIED Jast birthday) WIDOWED DIVORCED 10o USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 12 CITIZEN OF WHAT during most of working life, eyen if retired) **COUNTRY?** 13. FATHER'S NAME remaval 15 WAS DECEASED EVER IN U.S ARMED FORCES? 16. SOCIAL SECURITY NO 17 INFORMANT (Yes, no, or unknown) (If yes give war or dates af service 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) INTERVAL BETWEEN burial-transit burial, cremat PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ONSET AND DEATH ARCINOMA DUE 10 Conditions, if ony, which gove (b) rise ta immediate cause (o). DUE TO stoting the underlying cause PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19 WAS AUTOPSY PERFORMED? YES 1 NO [ğ 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20g ACCIDENT WAS UNDERLYING [] OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame, farm, (City or town) (County) (State) Hour 'a.m. Not While factory, street, office bldq, etc.) 19 of work TO FUNERAL DIRECTOR: After 21 I certify that (!) (this haspital) strended the deceased fram 19 60, ta 19 6 7, and that death accurred at 1.70 P.M., fram causes and an the date stated above saw the deceased alive an 220 SIGNATURE 22b. DATE SIGNED age . 30.1 M.D. PHYS DIRECTOR director, page shauld be filed 22c PHYSICIAN'S 22d ADDRESS CONN. 23d LOCATION (City or Town) (County) 25g REYD BY REGISTRAR 2Sb REGISTRAR'S SIGNATURE VR A15 (4) 25M 1/67



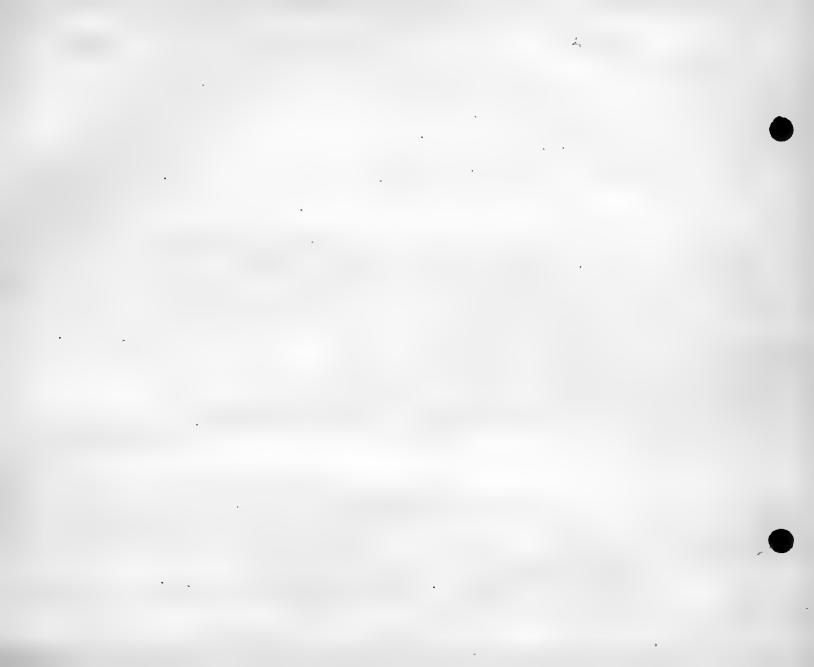
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05420 MEDICAL EXAMINER'S CERTIFICATE OF DEATH PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived if institution a COUNTY Montgomer **b.** COUNTY o STATE Poge MAONT GENZERS Maryland MARYLAND r LENGTH OF STAY IN 16 c CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) ueans d NAME OF HOSPITAL OR INSTITUTION (II not in haspital, give street address) IS RES DENCE ON A FARM? ng with form 2315Blue Ridge A Give Poges NO X 24 hours ofter death NAME OF DATE Jouant Manth Day Year OF DEATH DECEASED 19 6 S SEX IF UNDER MARRIED Months Hours in Item 18. Sept 1896 WIDOWED DIVORCED event within 72 hours ofter death 10a USUAL OCCUPATION (Give kind of work dane 10b K ND OF BUSINESS OR 11. BIRTHP, ACE (State or fore an country 12 CITIZEN OF WHAT Offi INDUSTRY L. House COUNTRY during most of working the even if ret red) Resident Manager Mobile, Alabama
14 MOTHER'S MA DEN NAME in pencil in Examiner's 13 FATHER'S NAME This certificate should be executed within Unknown Unknown 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 17 INFORMANT e, writing the word 'pending' is forworded to the Chief Medical (Yes, no, or unknown) (If yes give war ar dates of service) Mrs. Ellen L. Sherwood 807 Lanar say NoINTERVA BETWEEN 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) ONSET AND DEATH burial-transit PART I DEATH WAS CAUSED BY erebral Hemorihage Massive DUE TO in any Arterio Scherosis. Senere Years Conditions, if ony, which gave rise ta immediate cause (a), DUE TO stating the underlying cause or removol, and last PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19 WAS ALTOPSY PERFORMED? NO 20a EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) 3 should PRIMARY ar CONTRIBUTING CAUSE OF DEATH files. MEDICAL 20c TME OF NJURY Month, Day Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, 20f (City ar tawn) (County) (Stole) Haur a.m. Not Wayle foctory, street, office bldg, etc.) may be retained for your FUNERAL DIRECTOR: Page at work nspection X Inquiry X. 21. I certify that I taok charge of the remains described above held an Autopsy X. and in my apinian Natural causes X the funeral director. death resulted fram Accident . Surcide Hamitide Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED TO FUNERAL DI Health prior t SIGNATURE NAME Type) Address (Street, city, town, or county) 236 DATE THEREO! 23d LOCATION (City or Town) 23g BURIAL FREMATION (County) REMOVAL Specily) lington National Cem. Arlington. VR A15ME (5) 6M 167



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 05421 PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY o. STATE b. COUNTY MARYLAND JI GOMO The low requires that the death certificate be executed within 24 hours ofter CLENGTH OF STAY IN 16 c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) b CITY OR TOWN (If autside corporate limits write RURAL and give pegrest town WHEATON d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address d. STREET ADDRESS e. IS RESIDENCE ON A FARM? 2308-13/URIdgE YES NAME OF 4. DATE Year OF DECEASED 196 Type or print) DEATH IF UNDER 1 YEAR IF UNDER 24 HRS 5 SEX 9 AGE (In years 6 COLOR OR RACE 7 MARRIED **NEVER MARRIED** please remove last birthdoy) Manths Hours MALE and in ony WIDOWED DIVORCED 70 Yrs. signed by the attending physician and burial-transit permit. Then please rem 12 CITIZEN OF WHAT 10a USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) COUNTRY 2 during most of working I te, even if retired) INDUSTRY 14. MOTHER'S MAIDEN NAME 13 FATHER S NAME cremotion, or removol, William C. Ma-sez Varriet Asthury IS WAS DECEASED EVER IN U.S ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO Address c.hamon (Yes, nasprunknown) (If yespive wor or dates of service NTERVAL BETWEEN CAUSE OF DEATH (Enter any one cause per line for (g), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Page 4 may be retained by the hospital or attending physicion. DHE TO burial, Conditions, if ony, which gove (b) rise to immediate cause (a). DUE TO stating the underlying cause os the prior to l lost. 19. WAS AUTOPSY PERFORMED? PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) of Heolth YES T NO 200 ACCIDENT WAS UNDERLYING [205 DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) with the State Dept. MEDICAL (State) 20e. PLACE OF INJURY (Home, form. (County) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED (City or town) factory, street, office blda., etc.) Hour o.m. After at wark 2]. I certify that (I) (this hospitel) affended the deceased from M, from causes and on the date stated above. O FUNERAL DIRECTOR: saw the deceased alive on and that death accurred at 22b. DATE SIGNED 220 SIGNATURE **ATTENDING** DIRECTOR PHYS director, page should be filed 22d ADDRESS 22c. PHYSICIAN S NAME (Type) NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) BURIAL CREMATION 23b. DATE THEREOF 23a REMOVAL (Specify) iesu con le ctera 2So. REC'D BY REGISTRAR 2Sb. RÉGISTRAR'S SIGNATUR VR A15 (4) 20 M 1/66 8434 GOOMING luer.o SALINIE SHEARD



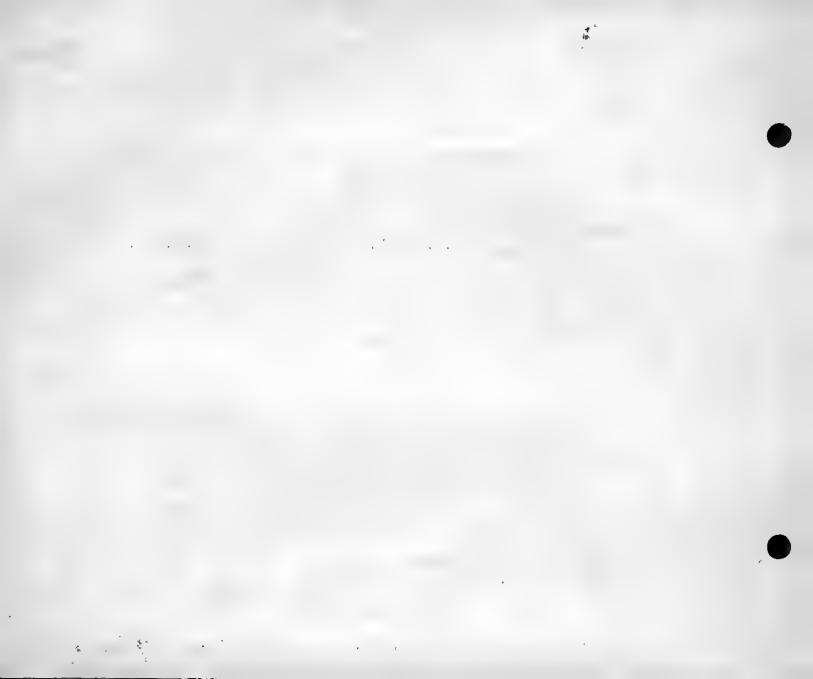
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH law requires that the death certificate be executed within 24 hours after death by the attending physician and campletely filled in by the funeral ransit permit. Then please remave carban papers. Pages/ and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. COUNTY o. STATE b. COUNTY MARYLAND c. LENGTH OF STAY IN 16 CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits SILVER SPRI DA STREET ADDRESS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, GIVE street oddress) FOREST 6-ROUE NO Z NAME OF First DATE Month Lost Doy Year DECEASED CHUSTORYMARMADUKE 19 67 0350 DEATH IF UNDER 1 YEAR S. SEX 6. COLOR OR RACE 9. AGE (In years IF UNDER 24 HRS. DATE OF BIRTH 7 MARRIED **NEVER MARRIED** lost, birthdoy) Months Doys Hours 20 WIDOWED DIVORCED 2_yrs 10b, KIND OF BUSINESS OR 12. CITIZEN OF WHAT 10a USUAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (County & Stote, or foreign country) during most of working life, even if retired) INDUSTRY COUNTRY? 15 KOAD COUSTRUCT 13" FATHER S NAME INFORMANT (Yes, no, or unknown) (If yes give war or dates of service) EK-MRS G-SANFO 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c))
PART I DEATH WAS CAUSED BY: INTERVAL BETWEEN burial-transit ONSET AND DEATH IMMEDIATE CAUSE (o) DUE TO signed ! TERMINAL PUEUMONIA Conditions, if any, which gave nse to immediate couse (o), DUE TO stating the underlying couse as the O FUNERAL DIRECTOR: After this certificate has been last. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) far use CONGEST YES NO 200 ACCIDENT WAS UNDERLYING 20b DESCRIBE HOW INJURY OCCURRED, (Enter noture of injury in Port I or Port II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, (City or town) (Stote) 20c. TIME OF INJURY Month, Day, Year (County) Hour o.m. factory, street, office bldg., etc.) Not While 21. I certify that (I) (this haspital) attended the deceased fram_ 1962 to 1967, that (I) (we) last 1967, and that death occurred at social, fram causes and an the date stated above. saw the deceased alive an 22o. SIGNATURE 22b. DATE SIGNED ATTENDING PHYS. M.D. DIRECTOR director, page shauld be filed 22c PHYSICIAN'S 22d. ADDRESS NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 230 BURIAL, CREMATION DATE THEREOF (County) (State) REMOVAL (Specify) Suitland Maruland Cenetery 2Sb. REGISTRAR'S SIGNATURE 25o. REC'D BY REGISTRAR FLINERAL DIRECTOR VR A15 (4) 20 M 1/66



| 2/ 1 1 | MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | |
|--|--|-------------------------------------|
| $(M)_{\alpha}$ | 05423 CERTIFICATE OF DEATH | 5421 |
| r death funeral 1 and 1 | 1 PLACE OF DEATH o. COUNTY Montgomery MARYLAND 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence be o. STATE virginia b. COUNTY | efore odmission |
| te be executed within 24 haurs after denthing and campletely filled in by the funeral use canave carban papers. Pages 1 and 2 and in any event, within 72 hours after death. | b. CITY OR TOWN (If autside carparate limits, write RURAL and give nearly RURAL and give nearly Bethesda (rural) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearly RURAL a | |
| d in pers | d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS | e. IS RESIDENCE ON A FARM? |
| hin (| Naval Hospital 2545 Hillsman Street 3. NAME OF First Middle Lost 4 DATE Manth | YES NO X |
| wit etely arbar | DECEASED (Type of print) George Thomas MARSHALL OF DEATH April 3 | 19 67 |
| xecuted within 24 I campletely filled in nave carban paper ny event, within 72 | S SEX 6. COLOR OR RACE 7 MARRIED NEVER MARRIED 2 B DATE OF BIRTH Male Cauc WIDOWED DIVORCED Dec. 14, 1966 9. AGE (In years last birthday) Manths Dor yrs. 3 | |
| he be e | 100 USUAL OCCUPATION (G.ve kind of work done during No Party Land 2 CITIZEN (County & State No Party Land 2 COUNTY N/A Andrews Air/Fore Base | OF WHAT RY? USA |
| ifical nysici ral, d | 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME | |
| cert Ig pl Ther mav | Robert M. Marshall Grace Evelyn Harrison | |
| eath andir nit. or re | 15 WAS DECEASED EVER IN US ARMED FORCES? (Yes, no | |
| ATENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after dentetaned by the haspital or attending physician. CTOR: After this certificate has been signed by the attending physician and campletely filled in by the funeral shauld be detached far use as the burial-transit permit. Then please emave carban papers Pages I and with the State Dept. at Health priar to burial, cremation, or remaval, and in any event, within 72 hours after deat | TIP CALISE OF SEATH (Fotor goly one cause per line for (a) (b) and (c)) | INTERVAL BETWEEN ONSET AND DEATH |
| : The lot attention to the has to use as alth princip | PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) | 19. WAS AUTOPSY PERFORMED? YES NO |
| TO HOSPITAL GR ATTENDING PHYSICIAN: The law re Page 4 may be retained by the hospital or attending TO FUNERAL DIRECTOR: After this certificate has been a director, page 3 shauld be detached for use as the Is shauld be filed with the State Dept. of Health priar to be a shauld be filed with the State Dept. | 20a. ACCIDENT WAS UNDERLYING 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part II or Part II of item 1B.) 20c. TIME OF INJURY Manth, Day, Year Hour o.m. 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, factory, street, affice bldg, etc.) 20f. (City or town) (County) | |
| VG PHY / the hr er this edetacl | p.m. 14 at work 🗀 at work 🗀 | , , |
| TENDIR TRE by R. Afte Suld be the Ste | 21. I certify that (% (this haspitol) attended the deceased from March 28 , 19 67, to April 3 , 19 67, saw the deceased alive on April 3 , 19 67, and that death accurred a 30A M, from causes and on the | date stated obove. |
| OR AT OR AT UIRECTO | | 3, 1967 |
| PITAL may be ERAL Dir. pag | NAME (Type) Jerry J. Tomasovic, M. D. 22d ADDRESS Naval Hospital, Bethesda, Md. | |
| O HOSPITAL Page 4 may O FUNERAL I director, pag shauld be fil | Burnal (Specify) 4/5/67 Arlington National Cemetery Arlington, Virgi | unty) (Stote) nia |
| VR A15 (4) 20 M 1/66 | 24. FUNERAL DIRECTOR ALLE ADDRESS Church, ARROLET BY BE RAR JUST Falls Church Funeral Home, 1102 West Broad St. DATE | THE . |



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05424 CERTIFICATE OF DEATH carbon papers. Pages 1 and 2 ent, within 72 hours ofter death. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission p. COUNTY MARYIAND MOINTGOMERY b CITY OR TOWN (If outside carparate limits. E LENGTH OF STAY IN 16 c (ITY OR TOWN (If autside carparate limits, write RURA), and give negrest town) write RURAL and give nearest town) requires that the death certificate be executed within 24 hours AKOMA PARK completely filled in d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e IS RESIDENCE ON A FARM? NO X NAME OF Middle DATE Month . Year DECEASED OODRO (Type or print) 6 COLOR OR RACE IF UNDER I YEAR IF UNDER 24 HRS AGE (In years 7. MARRIED NEVER MARRIED remove last birthday) Months Doys and in any DIVORCED WIDOWED puo 10h KIND OF BUSINESS OR 12 CITIZEN OF WHAT or foreign country) physician a nen please U.S. Gov't. COUNTRY? 13. FATHER'S NAME burial-tronsit permit. Then pi burial, cremation, or removal, AIRE 17. INFORMANT 16. SOCIAL SECURITY NO. Records 86**C** /18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). INTERVAL BETWEEN ONSECTAND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) signed by DUE TO Conditions, if any, which gave rise to immediate cause (a), DUE TO stoting the underlying couse be detoched for use as the State Dept. of Health prior to WAS AUTOPS PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(c) YES D NO certificate 200. ACC DENT WAS UNDERLYING [20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) OR CONTRIBUTING CAUSE OF DEATH TO FUNERAL DIRECTOR: After this certi-director, page 3 should be detoched (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20c. TIME OF INJURY Month, Day, Year 20e. PLACE OF INJURY (Home, form, 20f (C by or town) (County) (State) Hour o.m. factory, street, office bldg., etc.) Not While of work at work 21. I certify that (1) (this hospital) attended the deceased from March 27 , 1967, to april 5, 1967, that (1) (we) lost Poge 4 moy be retained saw the deceased alive on lastif 5 1967, and that death accurred at 10/AM, from causes and an the date stated above. 22a. SIGNATURE 22b. DATE SIGNED director, page 3 should be filed v M.D. DIRECTOR PHYS. PHYS. 22d. ADDRESS 22c. PHYSICIAN'S Dr. NAME (Type) Traum 23c NAME OF CEMETERY OF FRAMERY
Baltimore National 230 BURIAL, CREMATION, Baltimore 23b. DATE THEREOF 4/10/67 B REMOVAL Specify) 25b REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR **ADDRESS** 250 REC'D BY REGISTRAR VR A15 (4) 25M 1/67 Francis Gasch's Sons Hyattsville, Md.



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 2120' 95425 CERTIFICATE OF DEATH y filled in by the funeral on 2 and 2 sithin 72 hours after death requires that the deoth certificate be executed within 24 hours after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a COUNTY MONI MARYLAND GOMERY C LENGTH OF STAY IN 16 c CITY OR TOWN (If autside carparate timits, write RURAL and give nearest tawn) CITY OR TOWN (If outside corporate limits, rite RDRAL and give nearest town) 5dA4S e IS RESIDENCE ON A FARM? NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NO Z Middle First 4. DATE Day Year please remove carbon DECEASED W. 28 AMES ARRIC 19 (Type or print) DEATH S SEX 9. AGE (In years IF JNDER 24 HRS 6 COLOR OR RACE DATE OF BIRTH 7. MARRIED NEVER MARRIED birthday) Haurs WIDOWED DIVORCED the ottending physician and isit permit. Then please rept 12. CITIZEN OF WHAT 1Da USUAŁ OCCJPATION (Give kind af wark dane 106 KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or fareign country) during most of working life, even if retired) COUNTRY INDUSTRY Agriculture Macon, Georgia 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME or removal, Patrick Mc Carrick Maru Cannon 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT (Yes, na, or unknown) (If yes give war ar dates at service 904-05-5034 Earlean Mc Carrick cremation, ONSET AND DEATH 18 CAUSE OF DEATH (Enter only one cause per line for (b), (b), and (c) buriol-tronsit PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) this certificate has been signed by Page 4 may be retained by the hospital or ottending physicion. O FUNERAL DIRECTOR: After this certificate has been signed by DUE TO Canditians, if any, which gave rise to immediate cause (a). DUE TO for use as the k f Health prior to b stating the underlying cause last. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO OCCURRED. (Enter nature of injury in Part 1 or Part II of item 18.) 200 ACCIDENT WAS JNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20e. PLACE OF INJURY (Hame, farm, 20f. 2Dc. TIME OF INJURY Month, Day, Year 2Dd. INJURY OCCURRED (City or town) (County) (State) Haur a.m. factory, street, office blda., etc.) Not While at wark at wark 21. I certify that (I) (this haspital) attended the deceased fram. and ther death accurred at 111 from causes and an the date stated above saw the deceased alive an 22a, SIGNATURE 22b. DATE SIGNED **ATTENDING** director, page 3 should be filed v M.D. PHYS. DIRECTOR PHYS. 22d. ADDRESS 22c PHYSICIAN S NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23a BURIAL, CREMATION 23b DATE THEREOF LOCATION (City or Town) (County) St. Roch's Cemetery New Orleans. 2Sq. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE ADDRESS yeargia Avenue VR A15 (4) 20 M 1/66 Inc. Silver Spring. ¿. Pumphey.



4 / E TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fundral director, page 3 should be detached for use as the burial-transit permit. Then please femove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and it and event, within 72 hours after death. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after Page 4 may be retained by the hospital or attending physician.

VR A15 (4) 20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 05494 051.95

| -1 | | | 0.03:63 |
|------|---------------|--|--|
| | l. | PLACE OF CEATH | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) |
| | | a. COUNTY | a. STATE ' /// Jab, COUNTY |
| - | | MARYLAND | 1110 - Thornas many |
| ì | | b. CITY OR TOWN (if outside corporate umits, c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) |
| 1 | - | write RURAL and give pearest town) | I d'I de la |
| ł | | lakoma Park I month | dille Merrick 1100 1 |
| | | d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | d. STREET ADDRESS |
| 1 | | | 8202 N. H. AVELLONA FARM? |
| | \mathcal{L} | ak haven Convoles cent Home | YES NO X |
| | 3. | NAME OF First Middle | Last 4. DATE Morth Oay Year |
| | | DECEASED | OF (1 1 20 177 |
| | | (Type or print) Eva F. Mech | esney DEATH april 28 1967 |
| | 5. | SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED | 8. DATE OF GIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. |
| | | | last pirthday) Months Days Hours Min. |
| | | WIDOWED DIVORCED | Jet 20, 1872 94 yrs. |
| | 10a | USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR | 11. BIRT HPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT |
| | qur | ing most of working life, even if retired) INDUSTRY | COUNTRY? |
| - | <u> </u> | ureau of fr. + Engraving U.S. good | D.C U.S. |
| | 13. | FATHER'S DAME | 14. MOTHER'S MAIDEN NAME |
| | | T 1 xc. 0 | 14 20 111 |
| | | Joseph Nicholson | Mary Klizabeth |
| | 15 | . WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 1 17. | INFORMANT Address Siver Spring |
| | (10 | | |
| | | | 5. May, 8200 New Hampshirelye. Md. |
| | | 18. CAUSE OF CEATH [Enter only one cause per line for (a), (b), and (c). 1/2 | INTERVAL BETWEEN |
| | | PART I. DEATH WAS CAUSED BY: | ONSET AND DEATH |
| | | IMMEDIATE CAUSE (a) | |
| | - 1 | DUE TO AND | |
| | | Conditions If any which I | her has the low Behilde one |
| | | gave rise to immediate (b) | |
| | | cause (a), stating the DUE TO | |
| | | underlying cause last. (c) | |
| | 8 | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELA | TED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 119. WAS AUTOPSY |
| 2 | Ē | THE THE PROPERTY OF THE PARTY O | PERFORMED? |
| | CERTIFICAT | | YES ND |
| | 44. | 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCU | IRRED. (Enter nature of injury in Part I or Part II of Item 18.) |
| j | 02 | OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | thomas famous include at holys, in soft soft as some soft name wash |
| | 3 | (IF EITHER, NOTIFY MEDICAL EXAMINER) | |
| | P. | 20c, TIME OF INJURY Month, Day, Year 20d, INJURY OCCURRED 20e, PLA | CE OF INJURY (Home, farm, 20f. (City or town) (County) (State) |
| | 묽 | Hour a.m. While - Not While - facto | ry, street, office bldg., etc.) |
| | MEDICAL | p.m. 19 at work at work | * |
| | | 21 Leartifu that (I) (this bearital) attended the decorated from | 1967 to #77 196 , that (I) (we) last |
| - 1 | | 21. I certify that (I) (this hospital) attended, the deceased from | |
| | | saw the deceased alive on 7/2/1964, and that | death occurred at (AM, from the causes and on the date stated above. |
| | | 22a. SIGNATURE () () () | 22b. DATE SIGNED |
| | | TEKN Kolohum | ATTENDING MED. STAFF DIRECTOR PHYS. |
| | | 22c. PHYSICIAN'S M.D | DIRECTOR PHYS. 1 |
| , | | NAME (Type) of 2 H W. Lo It o N | 220. ADDRESS I/ n I KO . P. MY |
| | | C Kas PI VV | 1401 Dane la |
| | 23a | BURIAL CREMATION, 23b. DATE THEREOF / 23c. NAME OF CEMEJERY | OR CREMATORY 23d. LOCATION (CRy, town or county) (State) |
| | 400 | REMOVAL (Specify) | The state of the s |
| | 1 | 1 - 11-144 The CA F COL () 11 | 1200 12 CM Elade 21200120 16 |
| | 24 | . FUNERAL DIRECTOR/ ADDRESS %/ 5. | 258. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE |
| | | W M Charles land | MAY A MOOT OFFI O |
| -ter | | 1. 1. C. 114 111: 27 - , 1712 - 371 | DAMAY 4 1967 (Clearles Judge |
| | | | |



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 35427 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DEPT. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution. Residence before admission) o. COUNTY, Nont gomes o. STATE b. COUNTY Montgomery MARYLAND b. CITY OR TOWN (If outside corporate I mits CLENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate fimits, write RURAL and give negrest town) write RURAL and give nearest town Burtons. Ville W. ToKann d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS e IS RESIDENCE ON A FARM? Office alang with farm 4519 Sandy SPring Rd Item 18. Give Pages YES NAME OF 4. DATE Month Dov DECEASED Wine Mc C-longham (Type or print) DEATH within 72 haurs after death S. SEX 6 COLOR OR RACE B. DATE OF BIRTH 9 AGE (In years last birthdoy) Months Dovs Hours DIVORCED WIDOWED 10o USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 12 CITIZEN OF WHAT during most of working life, even if retired COUNTRY 3 ROTUCKY .⊑ the Chief Medical Examiner's pencil ATHER'S NAME 14 MOTHER'S MAIDEN NAME be executed within OUGAD Enama 17. INFORMANT 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO permit. (Yes, no, ar unknown) (f yes give war or dates of service 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c), INTERVAL BETWEEN Hemosthage HThrombosisk PART I. DEATH WAS CAUSED BY ONSET AND DEATH in any event Middle-Cerebial Gttery This certificate shauld writing the word Canditions, if any, which gove ₽ rise to immediate couse (a), stoting the underlying couse terio Selero sismenera lizal remaya! PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO 19. WAS AUTOPS' PERFORMED? 200 EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING CO 3 shauld Б General. Cinesthesiz increment strain in Vercul CAUSE OF DEATH MEDICAL 20e. PLACE OF INJURY (Home, form. 20¢ T.M. OF INJURY Month, Day, Year (City or town) Hour o.m Not While factory, street, office bldg., etc.) of work 21. I certify that I taok charge of the remains described above held an Autapsy 🔀 Inspection 💢 Inqu'ry 📝 may be retained far FUNERAL DIRECTOR: and in my opinion Natural causes death resulted from: Accident Suicide [Homicide Undetermined manner funeral directar 5 may be retaine TO FUNERAL DIRE Health priar ta b CHIEF MEDICAL EXAMINER **ACTUAL** 22. DATE SIGNED SIGNATURE DEPUTY MEDICAL EXAMINER & **EXAMINER'S** NAME (Type) Address (Street, city, town, or county) 230 BURIAL CREMAT ON 23b DATE THEREOF 23c /WAME OF CEMETERY OR CREMATORY (County) (Store) REMOVAL (Specify) 24 FUNERAL-DIRECTOR 25b. REGISTRAR'S SIGNATURE 250 REC D BY REGISTRAR VR A15ME (5) Ochanter 6M 1/67

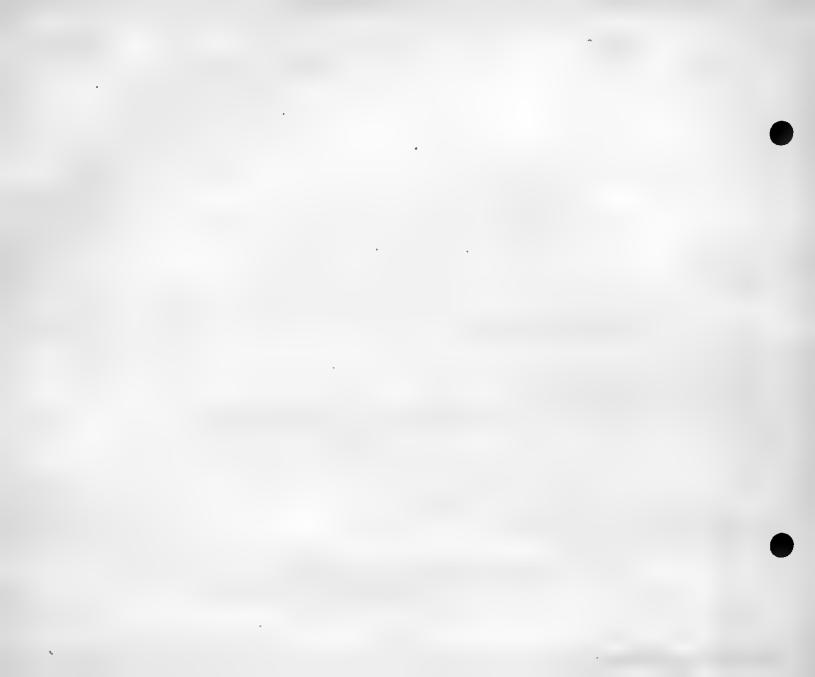


MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05428 CERTIFICATE OF DEATH filled in by the funeral papers. Pages I and 2 thin 72 hays offer death. requires that the death certificate be executed within 24 haurs after death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) · Montgomery o. STMaryland b. 10 My comery MARYLAND b. CITY OR TOWN (If outside corporate limits, C LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jakoma Park D.O.A. Silver Spring d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? Washington Sanitarium and Hospital 508 Wayne Avenue YES NO R 3. NAME OF 4. DATE Month Doy Year and campletely DECEASED (Type or print) Soretta OF DEATH Mc Donnell April Ц 1967 event remove to 6 COLOR OR RACE 9, AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. DATE OF BIRTH NEVER MARRIED April 25. lost birthday) Months emale and in ohy JOO_JSUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT tring most of working life, even if retired signed by the attending physician burial-transit permit. Then please burial-tremation, ar removal and i Properties Pennsulvania 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME John M. Cooceacc Crawley Katherine Windle 16 SOCIAL SECURITY NO 17. INFORMANT Address Huenne WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give wor or dotes of service) James A. Mc Donnell Ues CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c)) INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) physician. DUE TO Conditions, if ony, which gove rise to immediate couse (o), DUE TO stoting the underlying couse as the prior ta has been lost. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) WAS AUTOPSY PERFORMED? NO TO FUNERAL DIRECTOR: After this certificate 200 ACCIDENT WAS UNDERLYING [20b DESCRIBE HOW INJURY OCCURRED (Enter hoture of Injury in Port | or Port |) of item | 1B.) OR CONTRIBUTING COCAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20c TIME OF INJURY Month, Doy, Year 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (Stote) Rour a.m foctory, street, office blda . etc.) Not While directar, page 3 shauld be de should be filed with the State at work of work 12 no QU 190 1, to UNDW 21. I certify that (I) (this hospital) attended the deceased fram_ H. 1967, that (1) (we) last Page 4 may be retained 29 19(7), and that death accurred at 250AM, from causes and an the date stated above saw the deceased alive on MAN 220 STONATURE 22b., DATE SIGNED ATTENDING M.D. DIRECTOR PHYS. PHYS 22d, ADDRESS 22c. PHYSICIAN'S NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23o. BURIAL CREMATION. 23b. DATE THEREOF (County) Burial (Specify) Apr 8 Olivet Cemetery Washington. APR 7 196 FUNERAL DIRECTOR REGISTRAR'S SIGNATURE VR A15 (4) 20 M 1/66



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 95423 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY o. STATE Paruland MARYLAND b. CITY OR TOWN (If autside carporate limits, c LENGTH OF STAY IN 16 c CITY OR TOWN (If autside camarate limits, write RURAL and give nearest town) write RURAL and give nearest town) Painna Park d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS e. IS RESIDENC within 72 h ON A FARM? esta. Sa itari: and Varrita 7107 14th Ave wa YES NO 🗵 NAME OF 4 DATE Month Year remaye carbon DECEASED 19 vent, IF UNDER 24 HRS 6 COLOR OR RACE 9. AGE (In years SEX NEVER MARRIED last birthday) Months 7. 1y 20. alo WIDOWED 10a USUAL OCCUPATION (Give kind of work done JOB KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired) Donna. Acco. w.ta. it 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME ar remaval, Peter O. Ma Gint Sr. Rose P. whe IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT (Yes, na, or unknown) (If yes give war or dates of service) 75-17-9578 INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c))
PART I DEATH WAS CAUSED BY signed by the burial-transit GNSET AND DEATH IMMEDIATE CAUSE (a) DUE TO Zmangh. Conditions, if any, which gove rise to immediate cause (a), DUE TO stating the underlying couse has been last. 19. WAS AUTOPSY PERFORMED? PART IJ OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) NO O FUNERAL DIRECTOR: After this certificate 20g ACCIDENT WAS UNDERLYING 205 DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of Item 18.) OR CONTR BUTING ET CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) (City or town) 20c TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Hame, form, (County) (State) Not While Hour om. While foctory, street, office bldg., etc.) While at work at work director, page 3 should should be filed with the 22b. DATE SIGNED 22a, SIGNATURE STAFF PHYS. ATTENDING 4/20/67 M.D DIRECTOR 22d. ADDRESS PHYS. CIAN'S NAME (Type) 1746 KS+ N. W Foster 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Tawn) 23b DATE THEREOF (County) BURIAL, CREMATION, REMOVAL (Specify) Gate of Heaver Cemetery Silver Spring, Maryland 243 : ADDRESS ia Huenne 250 REC'D BY REGISTRAR 2Sb REGISTRAR S SIGNATURE VR A15 (4) inhreu. Lic.

MARYLAND STATE DEPARTMENT OF HEALTH



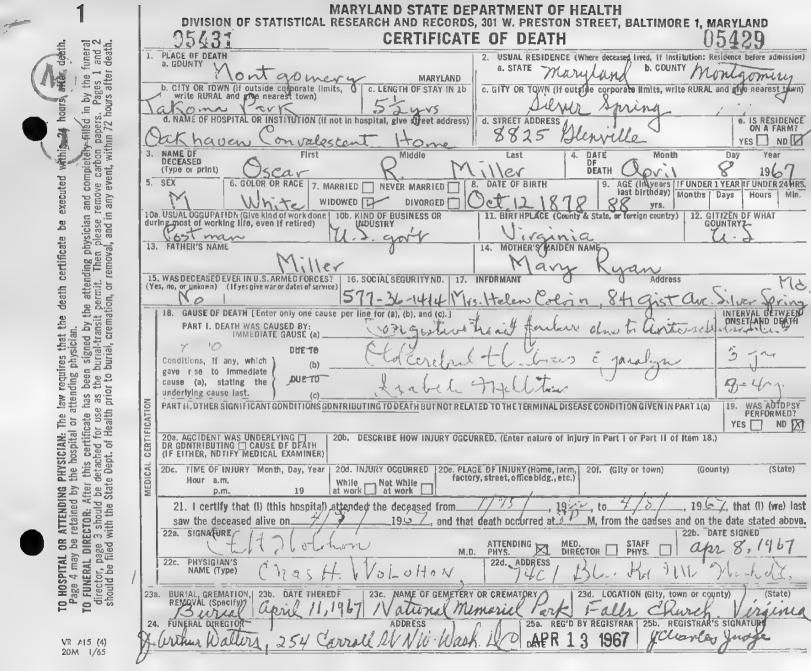
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 05430 PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) p. COLINTY MARYLAND b CITY OR TOWN (If outside corporate limits c LENGTH OF STAY IN 16 ide corporate limits, write RURAL and give nearest fawn) OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e. IS RESIDENCE YES NO NAME OF DECEASED DATE Month Year OF DEATH (Type or pnnt) IF UNDER 6. COLOR OR RACE NEVER MARRIED 9. AGE (In years 7. MARRIED last bitthday) Months Haurs Days WIDOWED 100 USUAL OCCUPATION (Give kind af wark done during most of warking life, even if refired) 12 CITIZEN OF WHAT 10b KIND OF BUSINESS 11. BIRTHPLACE (Caunty & State, or fareign country) 13. FATHER'S NAME 17 INFORMANT IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO (Yes, na, or unknown) If If yes give war at dates of service INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), ond (c).)
PART I DEATH WAS CAUSED BY: ONSET AND DEATH IMMEDIATE CAUSE (o) DUE TO Canditians, if any, which gave in sumonia (b) rise to immediate cause (a), DUE TO stating the underlying cause lost. 19 WAS AUTOPSY PERFORMED? PART H, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Kinsons DISENSE NO 200 ACC DENT WAS UNDERLYING [206, DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of Item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20e PLACE OF INJURY (Home, form, 20f (City or town) 20c TIME OF NJURY Month, Day, Year Haur a.m. (County) (Stote) factory, street, affice bldg., etc.) Not While 21 | certify that (1) (this hospital) attended the deceased from 2/26, 1967, ta 4.22, 1967, that (1) (we) last saw the deceased glive on 4.20 1967, and that death accurred at 2.35 M, from causes and on the date stated above. 2/26, 1967, to 4.22, 1967, that (1) (we) last 22o. SIGNATURE 22b DATE SIGNED DIRECTOR M.D. 22d. ADDRESS 22c. PHYSICIAN'S MD Carroll NAME (Type) 7701 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 230 BURIAL CREMATION. 236 DATE THEREOF Burial (Specify) Rock Creek, Cemetery Washington

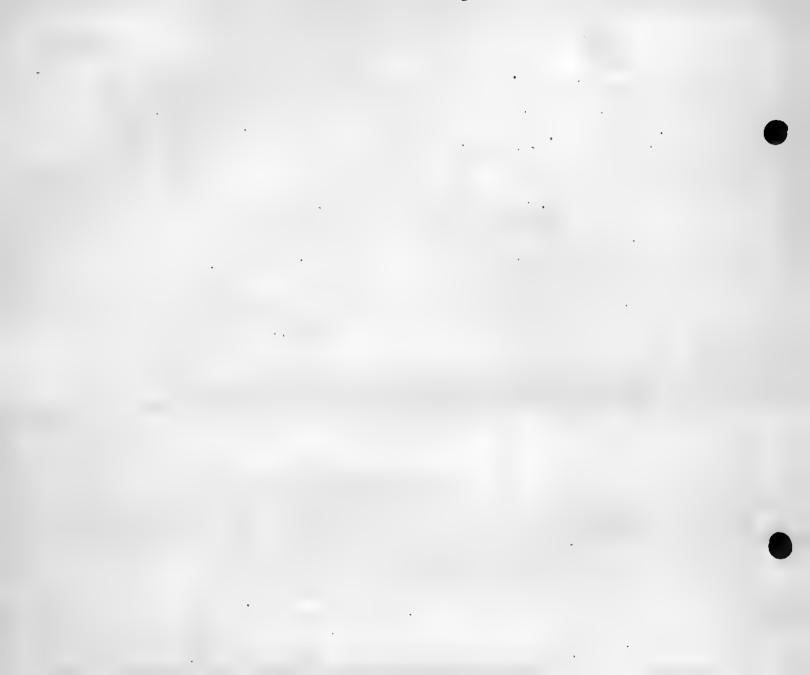
PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death filled in by the function papers. Pages 1 of thin 72 hours after d the attending physician and campletely finite permit. Then please remove carban signed by the attending physician and camplete burial-transit permit. Then please remove carb burial, crematian, or removal, and in any event, **TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires the Page 4 may be retained by the haspital ar attending physician. as the be detached far use as the State Dept, af Health priar to certificate TO FUNERAL DIRECTOR: After this VR A15 (4) 25M 1/67

24 FUNERAL DIRECTOR

250APR BEREGISTRIBET







MARYLAND STATE DEPARTMENT OF HEALTH



| | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | |
|--|---|--|
| FOR STATE | 05433 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05 | 431 |
| HEALTH DEPT | 1. PLACE OF DEATH OF COUNTY OF MONTGOMERY MARYLAND 2 USLAL RESIDENCE (Where deceased lived, if institution Residence by COUNTY OF STATE OF DEATH OF STATE | andV |
| -8 E E | MARYLAND b. (TY OR TOWN (If outside corporate I mits, write RJRAL and give new Maryland) b. (TY OR TOWN (If outside corporate I mits, write RJRAL and give new Maryland) c. (ITY OR TOWN (It outside corporate I mits, write RJRAL and give new Maryland) start SPEINS d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d STREET ADDRESS | e IS RESIDENCE |
| Poges 1, 2, a with form PM | 811 DALE DRIVE BOX 161 | ON A FARM? YES NO |
| after death 1 2. Give Pages 5. John with for 6. With The State | DECEASED (Type or print) GEORGE MITCHELL DEATH 4 - 6 | Pay Year 19 67 |
| 2 E | S SEX 6 COLOR OR RACE 7 MARRIED XX NEVER MARRIED B DATE OF BIRTH WIDOWED DIVORCED Sept 13 1912 9 AGE (In years lost bythdoy) Months Do Months Do | ys Hours Min |
| within 24 hours pencil in Item 18 xaminer's Office ile pages land 2 v | 10b. USUAL OCCUPATION (Give kind of work done during most of working ife, even if retired) 10b. KIND OF BUSINESS OR 11 BIRTHPLACE (Stote or foreign country) 11 BIRTHPLACE (Stote or foreign country) 12 CIT ZET COUNTRY 13 DISTRIBUTION (Give kind of working ife, even if retired) 14 CIT ZET COUNTRY 15 Patent Office 17 Kansas 18 US | A COF WHAT |
| in pencil i Examiner File page | George Robert Mitchell Lucy Day | |
| executed within anding" in pencil Medicol Examine permit. File page within 72 hours o | (Yes, no, or unknown) (If yes give war or dotes of service) Seventh S 17 INFORMANT 902 Seventh S 18 19 19 19 19 19 19 19 | t. |
| INER: This certificate should be executed within 24 hourse certificate, writing the word "pending" in pencil in Item should be forwarded to the Chief Medical Examiner's Officiles. 3 should be used as a burial-transit permit. File pages land than, ar removal, and in any event within 72 hours offer decident. | 18 CAUSE OF DEATH (Enter only one couse per line for (a), (b), ond (c).) PART 1. DEATH WAS CAUSED BY: MMEDIATE CAUSE (a) | INTERVAL BETWEEN ONSET AND DEATH |
| This certificate, writible forwar | PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NAL DISEASE CONDITION GIVEN IN PART . | 19 WAS ALTOPSY PERFORMED? YES NO |
| MINER: This the certificate, 4 should be found for files. 3 should be used a should be used only or removed the contraction. | 200 EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING CAUSE OF DEATH 200 DESCR BE HOW INJRY OCCURRED (Enter nature of injury in Port or Port II of item 18.) | |
| (AM) | 20c. T.ME OF INJURY Month, Doy, Year Hour a.m. P.m. 19 20d INJURY OCCURRED Of While of work 19 of | , |
| MEDICAL pleose executed of director. Placetoned for other pure pure precedence of the pure pure pure pure pure pure pure pur | death resulted from Notural causes Acerdago , Suicida , Homicida , Undetermined manner . ACTUAL SIGNATURE ACS STANT MEDICAL EXAMINER . ASS STANT MEDICAL EXAMINER . | 22. DATE SIGNED |
| O DEPUTY necessory, the funeral 5 may be 0 FUNERAL Health price | EXAMINER'S NAME (Type) 3 ELDEN COUNTY) 230 BURIAL CREMATION. 236 DATE THEREOF 23c NAME OF GEMETERY OF CREMATORY 23d LOCATION (CTy or Town) (Co. | -//67 |
| Q = € ~ Q = ∩ | REMOVALISPECTY) 4-9-C7 Chirast Church Bull-ond Hosels Function Ellicoff City APAR 11 1967 Chirasts SIGNI | TURE |
| | | |

Items 10&21 Film 387 4-2 MARYLAND STATE DEPARTMENT OF HEALTH



| - 1 | Item 20 Film 387 4-18-6?MARYLAND STATE DEPARTMENT OF HEALTH | |
|--|--|--|
| _ | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item #9 Film #4357 4417/67 py | |
| FOR STATE | 35434 MEDICAL EXAMINER'S CERTIFICATE OF DEATH | |
| HEALTH DEPT. | 1. PLACE OF DEATH o. COUNTY MARYLAND 2 USUAL RESIDENCE (Where decoased lived, if institution. Residence of STATE by COUNTY | (photographical) |
| delay and 3.4 A3. Pag | b CITY OR TOWN (If outside corporate limits, confidence of the corporate limits, write RURAL and give necessary in the confidence of the c | e neorest town) |
| PM. | d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS. | 2) O IS DESIDENCE |
| th If any delay ges 1, 2, and 3 form PM3. Per ate Department | The been bare. The the street of the street | e IS RESIDENCE ON A FARM? YES NO |
| after death. If 8. Give Pages 1, ajong with farm | 3 NAME OF First Middle Lost 4. DATE Month OF DECEASED (Type or point) Ella Gree Oscard Oscard Middle DEATH | Doy Year 7 |
| | S SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED B DATE OF B RTH S AGE in years 15 UNDER Months S 3 ost 5 th day) | |
| within 24 haurs n penci in Item I Examiner's Office File pages land2 Phours after deatt | | ITIZEN OF WHAT |
| | 13 FATHER'S NAME MOTHER'S MAIDEN MAME MOTHER'S MAIDEN MAME | |
| | Yes, no-grunknown) (It yes give war or dates of service) | e as alone |
| be executed "pending" in iief Medical E insit permit. F ent with,n 72 | 18 CAUSE OF DEATH (Enter only one cause per, line for (a), (b), and (pt) | INTERVAL BETWEEN |
| navid be executed ward "pending" i the Chief Medical rial-transit permit. | PART DEATH WAS CAUSED BY: IMMEDIATE CAUSE (0) LOBULAR PINEUMENIA, TAILATERA | ONST AND DEATH |
| wa wa the inal | Conditions, if ony, which gove) (b) BURNS, Ind = 3-2. Degree | WRERS |
| This certificate state, writing the se farwarded to be used as a bu remaval, and in a | nse to immediate couse (a). stoting the underlying cause (c) last. (c) | |
| certifi writing brward used c aval, a | PART II OTHER S GNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NAL DISEASE CONDITION GIVEN IN PART 1(0) | 19 WAS AUTOPSY PERFORMED? |
| S S To | 3 PATTY METAMORPHOSIS, LIVER | YES 4 NO |
| | 200 EXTERNAL CAUSE WAS PRIMARY'S OF CONTRIBUTING CAUSE OF INJURY Month, Doy, Year 201 Time of NJJRY Month, Doy, Year 202 Time of NJJRY Month, Doy, Year 203 Time of NJJRY Month, Doy, Year 204 Time of NJJRY Month, Doy, Year 205 Time of NJJRY Month, Doy, Year 206 Time of NJJRY Month, Doy, Year 207 Time of NJJRY Month, Doy, Year 208 Time of NJJRY Month, Doy, Year 209 PLACE OF INJRY (home, form, foctory, street, office bidg etc.) | |
| EXAMINER: cute the cert rage 4 should r your files :Page 3 should crematian, a | CAUSE OF DEATH. 20c TIME OF NIJRY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (trome, form, 20f (City or town) (Co | ounty) (State) |
| xam te th yaur yaur 'oge | 2:20 xm 3/20 96/ of work will home Gaithersburg M | |
| MEDICAL EXA please execute director. Page retained for you branch of the branch or to burial, creming to burial, creming the purily creming the pu | 21 I certify that I took charge of the remains described above, held on Autopsy X, aspection X, Inquiry X. | |
| MEDICAL Ilease exe director. I stained fo DIRECTOR | deoth resulted from: Noturol couses, Accident 🔀, Suicide, Homicide, Undetermined monner | |
| | SIGNATURE John 15. Ball - M.D. ASSISTANT MEDICAL EXAMINER | 22. DATE SIGNED |
| o DEPUTY MEDICAL Indecessory, please exect the funeral director. Post may be retained for S may be retained for Health prior to burial, | EXAMINER'S NAME (Type) DEPUTY MEDICAL EXAMINER Address (Street, city, town, ar county) | |
| necessor the fune 5 may b 10 FUNER | 230 BURIAL, TREMATION, REMOVE CREMETERY OR C | (County) (Stote) |
| M | 24 FUNERAL/DIRECTOR - O O ADDRESS 250 REC'D BY REGISTRAR 256 SEGISTRARS | |
| VR A15ME (5) | 724 FUNERAL DIRECTOR - L. Surve Ce Rockville, Md. 250 RECUBY REGISTRAR 250 RECUSTRARS | 0 |

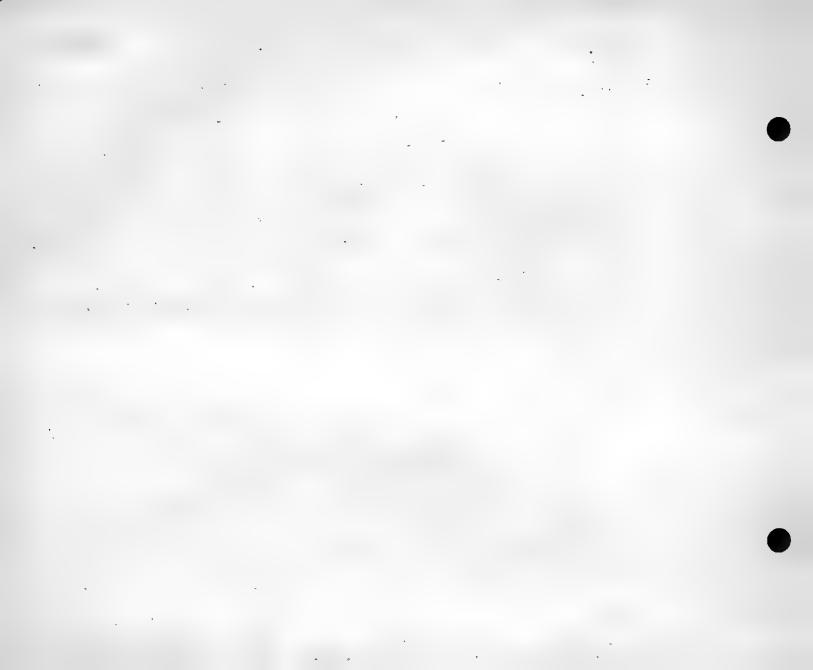




DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05438 CERTIFICATE OF DEATH The low requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2 USUAL RESIDENCE (Where, deceased lived, if institution: Residence before admission o COUNTY COUNTY tely filled in by the function papers. Pages 1 of within 72 haurs after d ntaomer MARYLAND b CITY OR TOWN (If outside corporate limity, c. LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest fown) write RURAL and give nearest town. RS 6 mo d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e IS RESIDENC ON A FARM? physicion and completely filled en please remove carban pape YES NO A NAME OF Middle 4. DATE Last Doy Year DECEASED OF anc noork (Type or print) DEATH 6. COLOR OR RACE 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 7. MARRIED NEVER MARRIED birthday) Months Hours ond in ony WIDOWED DIVORCED 10a, USUAL OCCUPAT ON (Give kind of work done 10b. KIND OF BUSINESS OR 12. CTIZEN OF WHAT (County & State, or foreign country) duting most of working life, even if fetired) 3. FATHER'S NAME or removal, IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) (If yes give war or dates of service) burial, cremation, signed by the o 1B. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: ONSEL AND DEATH IMMEDIATE CAUSE (a) Page 4 may be retained by the haspital or attending physician. DUE TO Conditions, if any, which gave rise to immediate couse (a). DUE TO stoting the underlying couse this certificate has been 19. WAS AUTOPS'
PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) NO 20a ACC DENT WAS UNDERLYING [1] 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 1B) OR CONTRIBUTING CAUSE OF DEATH be detached State Dept. of (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (State) Hour o.m. factory, street, affice bldg., etc.) While Not While at work of work 21. I certify that (1) Athis hospital) attended the deceased from director, page 3 should should be filed with the DIRECTOR: M, from causes and on the date stated obove saw the deceased diveran 19 63, and that death accurred at Co. 22a. SIGNATUR 22b DATE/SIGNED STAFF M.D. DIRECTOR 22c. PHYSICIAN 22d ADDRESS FUNERAL NAME (Type) U 230 BURIAL, CREMAT ON, 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) (State) REMOVAL (Specify) May 1st 1967 Bells Methodist Cemetery Camp Springs, 2 Erryland FUNERAL DIRECTOR **ADDRESS** 250. REC'D BY REGISTRAR 25b. REGISTRAR S SIGNATURE VR A15 (4) 25M 1/67 Bros. 1661-Good Hope Rd SE Wash DC



| , 1 | Items 18-21 Film 390 6-23MÁRŸLANDESTATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | |
|--|--|-----------------|
| FOR-STATE | 35437 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05435 | |
| delay 's mand 3 of 3 o | 1 PLACE OF DEATH a COUNTY MARYLAND b CITY OR TOWN of outside corporate Lm/s, c LENGTH OF STAY IN 1b CITY OR TOWN of outside corporate Lm/s, write RURAL and gold nearest town) | |
| Pro Part | Joseph Grand and give nearest toward 2 days Silver Spring d NAME OF HOSPITAL OR INSTITUTION (H not in haspital, give street address) 71/25h, San & Zlos Dital 9924 Woodby rn Rd YES NO | 12 |
| ofter death. If a 8. Give Pages 1, along with form with the State De | 3 NAME OF DECEASED (Type or prot) S SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED 3 B DATE OF BRTY 9 AGE (In years IFUNDER 174 ARRIED AGE IN MARRIED AGE IN MARRIED MEVER MARRIED AGE IN YEAR IF UNDER 24 Hours In Marries IFUNDER 24 Hours In Marries IFUNDER 25 Hours In Marries IFUNDER | 7 HRS Min |
| 4 haurs 1 fem 2 Office | Maje White Divorced 3/-43 22 vis 100 USJAL OCCJPATION (Give kind of work done during most of working rie, even if ret red) Neavy Machine operator Bldg. Construction Virain a like Construction (Livain) | TO . |
| id be executed within 24 rd "pending" in pencil in Chief Medical Examiner's transit permit. File pagestatent within 72 haurs after | Robert A. Moyer IS WAS DECEASED FUR N U.S ARMED FORCES? IS SOCIAL SECURITY NO 17 INFORMANT Addjess (Yes, no or unknown) lift yes give wor or dates of service) 14 SOCIAL SECURITY NO 17 INFORMANT Addjess | |
| | IB. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c)) PART I DEATH WAS CAUSED BY- ONSET AND DEAT A DUE TO ONSET AND DEAT | |
| rificate shou riing the wo arded ta the d as a burial , and in any | (b) cerebral laceration and intracranial stating life underlying cause (d). Company of the stating life underlying cause Company of the stating life underlying ca | |
| This certificate, writh be farwar labe used remayal, | YES NO | |
| INER: e certif shauld files. 3 shaulc | 20c TIME OF INJURY Manth, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame, form 20f (City ar tawn) (County) (State | , |
| ATCAL the executor. Per form of forms of form of forms of | 2:50 nour And the pm 4-27 19 67 of wark of work to street of the land of work to street of the land that the land | |
| o DEPUTY MEUC) necessary, please ethe funeral director s may be retained FUNERAL DIRECT Symbol Prior to buring | ACTUAL SIGNATURE SIGNATURE ASSISTANT MEDICAL EXAMINER (TYPE) BELOEN ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER (TYPE) BELOEN ASSISTANT MEDICAL EXAMINER | NED |
| TO DI | 230 BJRIAI, (REMATION, PROVIDED LANGE OF CEMETERY OR (REMATORY 23d LOCATION (Cty oy town) / (County) (State Provided (Specify) May 2, 1967 George Washington Cemetery Hyattsville, Maryland |) |
| VR A15ME (5) | John B. Thomas Thursten 8434 Georgia Avenue DMAY 4 1967 Clientes Judges | |



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 35438 CERTIFICATE OF DEATH The law requires that the death certificate be exercised within 24 hours after death. of ter death and completely filled in by the funeral PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o COUNTY Montgomery g. STATE b. COUNTY MARYLAND CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 15 c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) Bowie d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? within 72 h 2321 NO A 3. NAME OF Middle First Last 4. DATE Manth Year DECFASED VRPhy (Type or print) DEATH S SEX 6. COLOR OR RACE 7. MARRIED DATE OF BIRTH AGE (In years IF UNDER 1 YEAR 1F UNDER 24 HRS NEVER MARRIED lost birthday) Months Hours Dovs yna ni bna WHITC DIVORCED 10a USUAL OCCUPATION (Give kind of work dane KIND OF BUSINESS OR 10b 1) BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY signed by the attending physician burial-transit permit. Then please COUNTRY 9 VS.A 13 FATHER'S NAME burial, crematian, ar remaval, 14 MOTHER'S MAIDEN NAME Joseph 15. WAS DECEASED EVER IN U.S. ARMED FORCES? TAL SOCIAL SECURITY NO. INFORMANT Address (Yes, no, or unknown). (If yes give war or dates of service They 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c)) INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY ONSET AND DEATH Hyaline membrane disease IMMEDIATE CAUSE (a) Page 4 may be retained by the haspital ar attending physician. DUE TO Conditions, if any, which gove Prematurity rise ta immediate couse (a), DUE TO has been s ise as the b th priar tab stoting the underlying cause lost. 19. WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) be detached for use State Dept. of Health YES 2 NO this certificate 200 ACCIDENT WAS UNDERLYING 205 DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of Item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (Stote) Hour o.m. foctory, street, office bidg., etc.) TO FUNERAL DIRECTOR: After 21. I certify that (I) (this-hospital) attended the deceased from 1967, ta , 19<u>67</u>, that (1) (we) last director, page 3 shauld should be filed with the and that death accurred at 12:30 AM, from causes and an the date stated above. saw the deceased alive an 1967 22o SIGNATURE 226 DATE SIGNED 4/20/67 **ATTENDING** 8 DIRECTOR 22d. ADDRESS 22c PHYSICIAN'S NAME (Type) Albert J 704 Gorman Ave., Laurel, Md. Modlin, M.D. 23o. BURIAL, CREMATION DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (State) (County) 4/21/67 Gate of Heaven Silver Spring, Md. Fune ral Home-1331 Rockville.Md VR A15 (4) 20 M 1/66

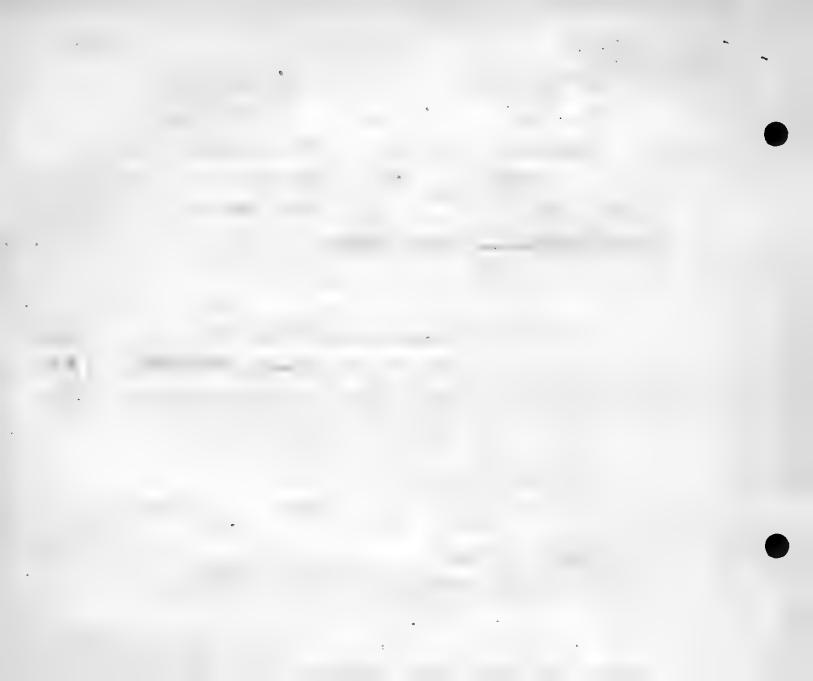
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1. MARYLAND CERTIFICATE OF DEATH furieral, and 2 r death. hours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. COUNTY b. COUNTY Pages 1 aurs after d Montaomeru MARYLAND Contameru b. CITY OR TOWN (if outside corporate limits. c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) on papers. Pag within 72 hours Silver Spring filled in wer day prina d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? 24 8712 Colesville Road Holy Cross Hospital ND X YES executed within completely carbon NAME OF First Middle DATE Month Day Last Year DECEASED (Type or print) Smuthe DEATH 19 6 AGE (In/years | IF UNDER 1 YEAR | IF UNDER 24 HRS. last by Inday) | Months | Days | Hours | Age. 5. SEX 6. COLOR OR RACE DATE OF BIRTH gan ease remove 7. MARRIED NEVER MARRIED 30. and 1885 in any white emale WIDOWED DIVORCED 10a. USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR O FUNERAL DIRECTOR: After this certificate has been signed by the attending physician director, page 3 should be detached for use as the burial-transit permit. Then please a should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT death certificate be during most of working life, even if retired) INDUSTRY Ireland Housewite Own home 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Mary Duinn Henry Smuthe 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address Meadowhille Road (Yes, no, or unknown) (If yes give war or dates of service) Dorothy M. CAUSE DF DEATH [Enter only one cause per line for (a), (b), and (c). INTERVAL BETWEEN ONSET AND DEATH The law requires that the PART I. DEATH WAS CAUSED BY: OR ATTENDING PHYSICIAN: The law requires that the retained by the hospital or attending physician. IMMEDIATE CAUSE (a) 3 32X MonTH Conditions, If any, which gave rise to Immediate DUE TD cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? CERTIFICATI YES NO K 20a. ACCIDENT WAS UNDERLYING TO DR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.) MEDICAL 20c. TIME OF INJURY Month, Day, Year I 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Home, farm, (State) 20f. (City or town) (County) factory, street, office bldg., etc.) Hour a.m. Not While While p.m. 19 at work at work 21. I certify that (i) (this hospital) attended the deceased from 1 that (I) (we) last saw the deceased alive on the M. from the causes and on the date stated above. and that ideath occurred at 4-22a. : SIGNATURE 22b. ATTENDING PHYS. M.D. DIRECTOR PHYS. Rage 4 may ADDRESS 22¢. PHYSICIAN'S 22d. director, p 23a. BURIAL, CREMATION. 23b. DATE THERED NAME OF CEMETERY OR CREMATORY LOCATION (City, town or county) (State) REMDVAL (Specify) 967 Parklawn Rockvil emeteru Maruland FUNERAL DIRECTOR REGISTRAR'S SIGNATURE **ADDRESS** 25a. REC'D BY REGISTRAR 25b. Huenne 74 Georgia VR A15 (4) 11/12 DAAMO 20M 1/65



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 05438 05440 OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. COUNTY MARYLAND Poges c. LENGTH OF STAY IN 16 b CITY OR TOWN (If outside corporate limits. c. CITY OR TOWN (If ourside corporate limits, write RURAL and give nearest town) repaye carbon papers. Types a any events of write RURAL and give nearest town and completely filled in remove carbon papers. d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS IS RESIDENCE ON A FARM? NO 3. NAME OF Middle Doy Year DECEASED (Type or print) APRIL DEATH 19 S. SEX IF UNDER 1 YEAR 9. AGE (In years IF UNDER 24 HRS 6. COLOR OR RACE **NEVER MARRIED** Jost birthdoy) Manths WIDOWED DIVORCED 10a USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or fareign country) 12 CITIZEN OF WHAT physician on please duringmast of working life, even if retired) COUNTRY? Maryland and S. ESTATE DALESMA 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME cremation, or removal. Reginald Murray Charlotte Young offending p 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17. INFORMANT Address Wife (Yes, na, ar unknown) i(If yes give wor ar dates af service) Same as Item 2. Unknown Thelma M. Murray INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c),) the Bronchiel. buriol-tronsit PART I. DEATH WAS CAUSED BY ONSEL AND DEATH neumonia. IMMEDIATE CAUSE (a) signed by O HOSPITAL OR ATTENDING PHYSICIAN: The law requires the Pmge 4 may be retained by the Bospital or attending physician. **DUE TO** buriol, o Cercinonna Canditians, if any, which gave rise to immediate couse (a). DUE TO stating the underlying cause has been 3 should be detached for use as the with the State Dept. af Health prior to Kidney - Ramoval -Carcinoma. d. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY PERFORMED? NO N YES 🗔 After this certificate 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Port II of item 18) 20g ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER MEDICAL 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c TIME OF INJURY Month, Day, Year Hour to.m. factory, street, office oldg., etc.) of work ot work 21. I certify that (I) (this haspital) attended the deceased from ta that (I) (we) last 1967, and that death accurred at 5AFUNERAL DIRECTOR: M, fram causes and an the date stated above. saw the deceased alive on 22o. SIGNATURE 22b. DATE SIGNED M.D. DIRECTOR PHYS director, page should be filed Old 22c. PHYSICIAL 22d. ADDRESS 7936 Georgétown NAME (Type JOHN G. BALL Bethesda. Maryland 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23a BUR AL CREMATION 23d. LOCATION (City or Town) (County) (Stote) BILLI AL Mt. Olivet Cemetery 0 4-21-67 Frederick. Marvland BY REGISTRAR 2 4 19 VR A15 (4) 25M 1/67 PUMPHREY, Bethesda, Maryland

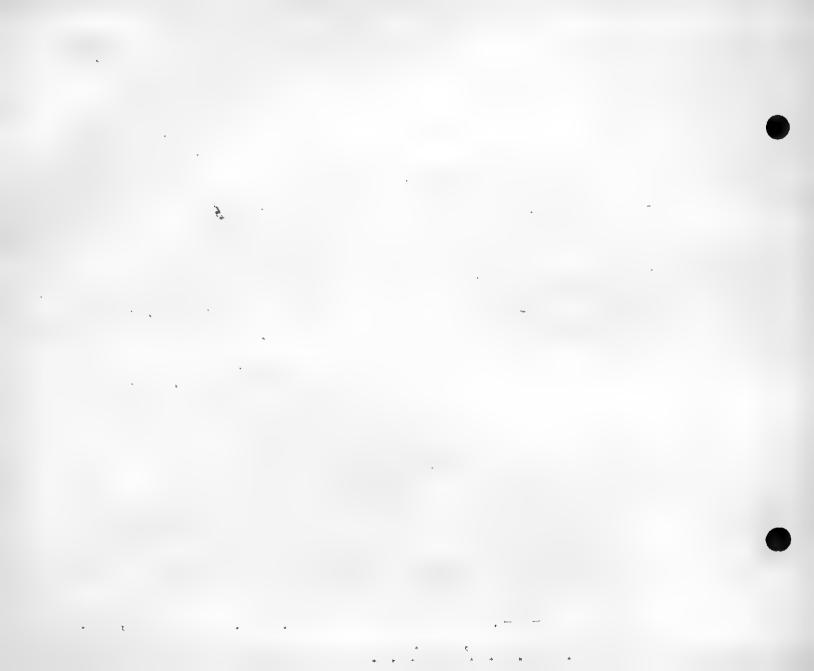


| _ 1 | | MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | |
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| <i>"</i> ≟ -≅8≟ | | 05441 CERTIFIC | | 05439 | | |
| death death | 1. | PLACE OF DEATH a. COUNTY | | ed lived, If institution: Residence before admission; | | |
| | | Mulamery MARYLA | a. STATE | b. COUNTY Montgerning | | |
| hours after ed in by the ers. Page 1 | | b. CITY OR TOWN (if outside corporate limits, write RURAL and give hearest town) c. LENGTH OF STAY II | 1 1b c. CITY OR TOWN (If outside corpor | ate Ilmits, write RURAL and give nearest fown) | | |
| ours in the | _ | Wheaton, 25 days | | a Park 121 | | |
| 4 = B = C | 10 | d. NAME OF HOSPITAL OR INSTITUTION (If not In hospital, give street add | 6819 Red | Tup Road e. is residence on a farm? | | |
| requires that the death certificate be executed withing physician. been signed by the attending physician and completely the burial-transit permit. Then please remove farbon or to burial, cremation, or removal, and in any event, with | 3. | NAME OF DECEASED (Type or print) GERTRUDE B | MYERS 4. DATE OF DEATH | APR, 18 1967 | | |
| executed and conference on any eve | 5. | SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED - Emale White WIDOWED DIVORCED | Sept 13.1887 | GE (In years IF UNDER'1 YEAR IF UNDER 24 MRs ast birthday) Months Days Hours Min. | | |
| te be executed ysician and complesse remove to and in any every | 10 du | USUAL OCCUPATION (Give kind of work done into kind of Business OR into most of working life, even if retired) LUK - Lywwwww Julya Lawy | 11. BIRTHPLACE (Country State, or | foreign country) 12. CITIZEN OF WHAT COUNTRY | | |
| e death certificate be the attending physician topermit. Then please attend, or removal, and in | 1 | | 14. MOTHER'S MAIDEN NAME | 1-18 | | |
| th certendir | 10 | . WAS DECEASED EVER IN U.S. AHMED FORCES? 16. SOCIAL SECURITY NO. 18, no, gr uniform) ((Ifyes gire wazer dates of service) | 17. INFORMANT | Address | | |
| deat e at perm ion, | _ | NU 597-03-0512 | Mr. Kerry Schroeders | #2 Crescent Cla T.F.M. | | |
| hat the deal cian. ed by the ai -transit pern , cremation, | | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | - Failure | INTERVAL BETWEEN ONSET AND DEATH | | |
| that sicial gned ial-tr | | DUE TO | o p | 110. | | |
| uires g ph) en si e bur | | Conditions, if any, which gave rise to immediate | rscular Kline | Charact you | | |
| red andin s be ior th | | cause (a), stating the DUE TO underlying cause last. (c) | | | | |
| CDIAN: The law requires that the ospital or attending physician. Certificate has been signed by the hed for use as the burial-transit. of Health prior to burial, cremat | CERTIFICATION | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NO | RELATED TO THE TERMINAL DISEASE CONDIT | TION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO | | |
| PHYSICIAN: the hospital this certific detached for | CERTIF | 20a. ACCIDENT WAS UNDERLYING [] 20b. DESCRIBE HOW INJURY OR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | OCCURRED. (Enter nature of injury in Part | l or Part II of Item 18.) | | |
| Par in a second | MEDICAL | 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20d. Hour a.m. 19 While at work at work | s. PLACE OF INJURY (Home, farm, 20f. (Cl) factory, street, office bidg., etc.) | ty or town) (County) (State) | | |
| E P A P B | 2 | 21. I pertify that (I) (this hospital) attended the deceased from | n 1967, to C | 1/24. 18, 196 /, that (1) (we) las | | |
| mu ⇔ ≥ | | saw the deceased alive on 22a. 1964, and | FINA | the causes and on the date stated above | | |
| AL OR nay be NL DIR page | VC. | 225 PARSCIAN'S CONTRACT VALLACE | M.D. ATTENDING MED. DIRECTOR DIRECTOR DIRECTOR D. F.A.C.A | STAFF PHYS. 4/18/67 | | |
| HOSPITAL Page 4 may FUNERAL I director, pa | 1 | jame (type) | Divor Branch Road N.W. | , | | |
| TO HOSPITAL Page 4 may TO FUNERAL director, pa | 23 | BURIAL CREMATION, 230- DATE THEREOF 23c. NAME OF CEM | ETERY OR CREMATORY, D.C. 23d/ LOCA | TION (City, town or county) (State) | | |
| VR A15 (4) | 2 | FUNERAL/DIRECTOR JACOBESS 254 Corre | 25a. REC'D BY REGISTE | | | |
| 15M 4-64 | 1 | | ZG - DAMEN D I 100 | | | |

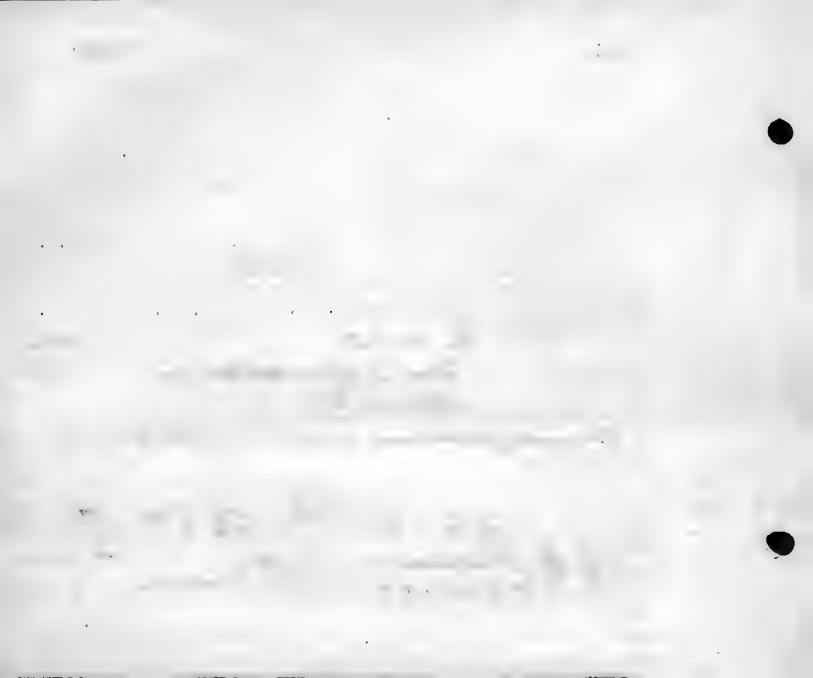




MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 35443 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DEPT. 1. PLACE OF DEATH USUAL RESIDENCE Pathere deceased lived, if institution, Residence before admission) o. COUNTY o STATE b COUNTY c. CITY OR TOWN (If outside corporate imits, write RURAL and give nearest town) and Strand 2 with the State Dep HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS te alang with farm ON A FARM? 3 NAME OF M ddle DECEASED OF DEATH (Type or print) S SEX DATE OF BIRTH IF JNDER 1 YEAR IF UNDER 24 HRS ast birthday) Months Bours within 72 hours after death WIDOWED X DIVORCED 100 USJAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT during most of working ite, eyen fretired) INDUSTRY COUNTRY? pages Chief Medical Examing 13 FATHER S-NAME 14 MOTHER'S MAIDEN NAME S WAS DEPEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO (Yes, no prunknown) (If yes give war or dates of service) 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c),) INTERVAL BETWEEN PART I. DEATH WAS CAUSED BYany event IMMEDIATE CAUSE (o) writing the ward DUE TO Conditions, if any, which gove rise to immediate cause (a), DUE TO stating the underlying couse ar removal, PART . OTHER SIGN FICANT CONDITIONS CONTRIBUTING TO DEATH BLT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 9 WAS AUTOPSY PERFORMED? NO 20g EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 11 of Item 18" 3 shauld PRIMARY CONTRIBUTING C CAUSE OF DEATH MEDICAL 20c TIME OF NIJRY Month Day, Year 20d INJURY OCCURRED 20e PLACE OF NJURY (Hame farm factory, street, office bidg petc. Not While While of work of work 21. I certify that I took charge of the remains described above, held on Actopsy Inspection 🔀 ond n my apinion Accident 🔀 Undetermined monner depth resulted from: Notural causes Suicide [Hamicide be retained CHIEF MEDICAL EXAMINER 22. DATE SIGNED ASSISTANT MEDICA, EXAMINER the funeral DEPUTY MFD CAL EXAMINER Address (Street, city, town, or county) 230 BURIA' CREMATION 23d LOCATION IC ty or Town, 0 REMOVAL (Specify) Arlington ington FUNERAL DIRECTOR Seph Gawler's VR A15ME (5) Sons, 6M 1/67



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 35444 requires that the death certificate be executed within 24 hours after death. 1. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) completely filled in by the further over corbon papers Pages 1 or o. COUNTY Maryland COLUNY OMEZ X any event, within 72 hours after Montgomery MARYLAND b. CITY OR TOWN (If autside corporate I mits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write PURAL and give nearest town)
Silver Spring mos Silver/Spring d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? Fairland Nursing Home Fally Yand/Road YES -NO X on comparation of 3 NAME OF Middle 4 DATE Day Year DECEASED (Type or print) OF DEATH Nobia April 19 19 67 S. SEX 6 COLOR OR RACE 9. AGE (In years IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. MARRIED DATE OF BIRTH NEVER MARRIED g fost birthday) Haurs Thite 27/1876 Rema Le WIDOWED IN DIVORCED Ida. USUAL OCCUPATION (Give kind of work done during most of working lite, even if retired) 11. BIRTHPLACE (County & State, or foreign country) 10b, KIND OF BUSINESS OR 12 CITIZEN OF WHAT COUNTRY'S A. INDUSTRY Graves Co., Ky. signed by the attending physical buriol-transit permit. Then ple 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME TO FUNERAL DIRECTOR: After this certificate hos been signed by the attending physi director, page 3 shauld be detoched for use os the buriol-transit permit. Then plishould be filed with the State Dept. of Heolth prior to buriol, cremotian, or remavol, Thomas Holt Cosby Bellzeria Gough 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address 4104 -(Yes, na. or unknown). If If yes give wor or dates of service Mr.O.T. Neal - St., Mt. Rainier, Md. 220-54-0333 1B. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c),)
PART I. DEATH WAS CAUSED BY: Son) INTERVAL BETWEEN ONSEL AND DEATH S.C. U.T. IMMEDIATE CAUSE (a) Page 4 may be retained by the hospital or attending physicion. DUE TO Conditions, if any, which gave rlingaleronis rise to immediate couse (a), DUE TO stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY PERFORMED? CERTIFICATION NO T 20a ACCIDENT WAS UNDERLYING □ 205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER! 20c TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Hame, farm, 20f. (City or town) (County) (Stote) Haur a.m. factory, street, affice bldg., etc.) Not While at work at wark 21. 1 certify that (1) (this hospital) attended the deceased fram. 67 and that death occurred at 9 2 M, from causes and on the date stated above. saw the deceased alive on. 220 SIGNATUR 22b. DATE SIGNED ATTENDING PHYS. M.D. DIRECTOR 22c. PHYSICIAN 22d ADDRESS NAME (TA 23o. BURIAL, CREMATION. 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) (Stote) REMOVAL (Specify) Burial Fort Lincoln Com. Colmar Manor, Md. 4/22/67 25b. REGISTRAR'S SIGNATURE ADDRESS Mt 24. FUNERAL DIRECTOR N.S. Rainier 250. RED BY REGISTRAR lley's Funeral VR A15 (4) 20 M 1/66 Home Inc. Maryland

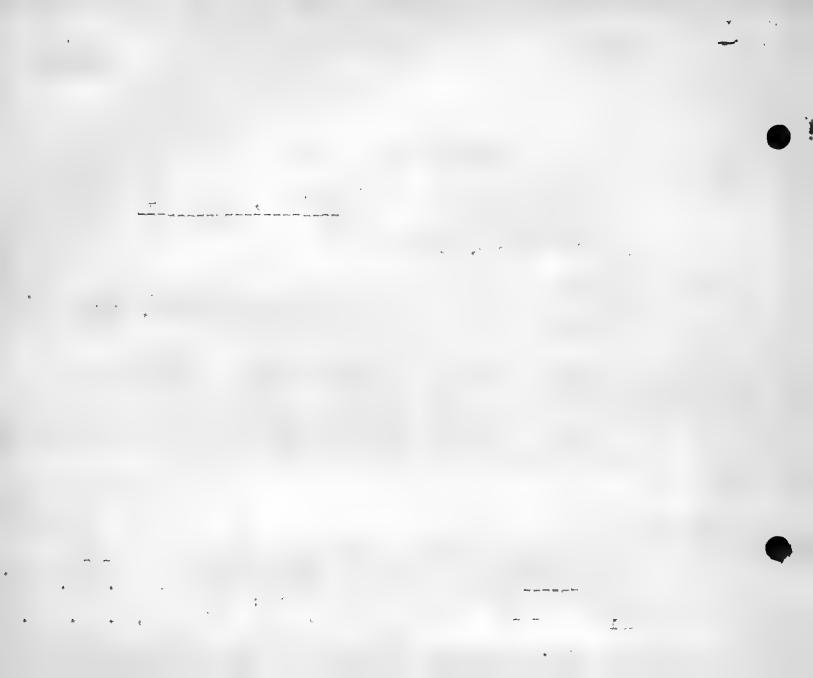


MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 05443 05445 The law requires that the death certificate be executed within 24 haurs after death de all by the funeral 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) PLACE OF DEATH o COUNTY b COUNTY o STATE - GE MONTGOMERY MARYLAND b CITY OR TOWN (If outside corporate imits, write RURAL and give nearest town) c. CITY OR TOWN (If outside corporate Emits, write RURAL and give nearest town) C. LENGTH OF STAY IN 16 filled in by th papers Pag thin 72 haurs GAITH ERSB URG OINTY. d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS IS RESIDENCE ON A FARM? filled i MONTGOMERY GUIERAL RT 1 Box 196 NO PE YES NAME OF 4. DATE remave carban First Middle Lost Month Dov Yeor campletely DECEASED OF DEATH BESSIT GAVER MEHOUSE APRIL 67 ever a IF UNDER 1 YEAR HE UNDER 24 HRS 6 COLOR OR RACE 8 DATE OF BIRTH 9. AGE (In years S. SEX 7. MARRIED NEVER MARRIED last birthday) Months Dovs Hours DHITTE 2-9-89 WIDOWED AND and in any DIVORCED pup 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired)

Housewife COUNTRYTSA please INDUSTRY attending physician termit. Then please Frederick Co., Md. 14, MOTHER'S MAIDEN NAME 13 FATHER S NAME burial, crematian, ar remiival, WILLIAM BURDETTE SALLY HILTON 15 WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give wor or dotes of service) 17. INFORMANT Address 16. SOCIAL SECURITY NO Item 2 Hilton B. Nehouse, INTERVAL BETWEEN IB. CAUSE OF DEATH (Enter only one couse per line for (o), (b) ond (c).) ONSET AND DEATH burial-transit PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) **O HOSPITAL OR ATTENDING PHYSICIAN:** The law remuires the Page 4 may be refained by the haspital ar attending physician. 4:101 DUE TO Conditions if any, which gove rise to immediate couse (a), DUE TO stoting the underlying couse as the has been lost. WAS AUTOPS PART II_OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMED? Health 1 YES SZ bronche priumina NO 200 ACCIDENT WAS UNDERLYING 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Part II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Year Hour om. foctory street office bldg . etc.) Not While of work to 4-16, 1967, that (1) (we) last 21. I certify that (I) (this haspital) attended the deceased fram_ , page 3 should be filed with the 1967, and that death accurred at 5 AM, fram causes and on the date stated above saw the deceased alive an___ TO FUNERAL DIRECTOR: 22b DATE SIGNED 220 S.GMATURE DIRECTOR ere MD PHYS 22d ADDRESS PHYSICIAN S Frederick Moomau, M.D. NAME (Type) directar, should b 23c NAME OF CEMETERY OR CREMATORY 230 BURIAL CREMATION 23b DATE THEREOF 23d LOCATION (City or Town) REMOVAL (Specify)
Burial April 19,1967 Salem Meth. Cedar Grove, Md. 25o. REC D BY REGISTRAR 2Sb REGISTRAR'S SIGNATURE **ADDRESS** 24 FUNERAL DIRECTOR VR A15 (4) 25M 1/67 Olin L. Molesworth, Damascus, Md.



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05446 CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Resid o. COUNTY p. STATE b. COUNTY b. CITY OR TOWN (If ourside corporate limits, MARYLAND requires that the death certificate be executed within 24 haurs after c. LENGTH OF STAY IN 1b c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) e. IS RESIDENCE ON A FARM HOSPITAL OR INSTITUTION (if not in hospital, give street address) , and in any everywithin NAME OF 4 DATE pon Middle Month DECEASED (Type or pont) DEATH 19 200 IF UNDER 1 YEAR IF UNDER 24 HRS SEX 7. MARRIED NEVER MARRIED remave WIDOWED DIVORCED . 100 USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stole or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY Heavy Equipment State Roads 14. MOTHER'S MAIDEN NAME crematian, ar remava UNKNOWN UNKNOWN 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17 INFORMANT 16. SOCIAL SECURITY NO Larry Nortolk Md. (Yes, ng, or unknown). (If yes give wor or dates of service Park Rd. Riviera NTERVAL BETWEEN ONEST AND DEATH 18 CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c)) burial-transit burial, cremat PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1621 DUE TO Conditions, if any, which gave nse to immediate couse (a), DUE TO stating the underlying couse PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED PERFORMED? NO Y certificate BRED (Enter noture of injury in Port I or Port II of item 18 OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20e, PLACE OF INJURY (Home, form, (Stole) 2Dr. TIME OF INJURY Month, Doy, Year 2Dd. INJURY OCCURRED (City or town) (County) factory, street, office bldg., etc) Hour o.m. Not While of work 21 I certify that (I) (this haspital) attended the deceased fram be retained M, from couses and an the date stated above. TO FUNERAL DIRECTOR: saw the deceased alive an and that death accurred at 22o, SIGNATURE 22b DATE SIGNED STAFF 4-3-67 DIRECTOR ADDRESS Silver 22c. PHYSICIAN'S University Blvd E. Md. Kennth Cruze 23c NAME OF CEMETERY OR CREMATORY Cem: 23d LOCATION (City or Town) (Stote) Co 23o. BURIAL CREMANONI 23b. DATE THEREOF (County) Washington National Suitland .Md. Geo. APPoper Marlbord'so RECD BY REGISTRAR 25b. REG STRAR S SIGNATURE 24 FUNERAL DIRECTOR VR A15 (III) Ritchie Bros. Funeral Home Maryland





MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 35448 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) PLACE OF DEATH signed by the attending physician and completely filled in by the funera burial-transit permit. Then please remove carbon papers. Pages 1 And o COUNTY o. STATE b. COUNTY MARYLAND requires that the death certificate be executed within 24 hours often b CITY OR TOWN (If outside cornorate limits E. LENGTH OF STAY IN 16 c. CITY OR JOWN (It butside corporate limits, write RURAL and give negrest town) d NAME OF AOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS ON A FARM within YES NO NAME OF please remove corbon Viiddle Lost DATE Month Doy Year DECEASED Type or print OF DEATH S. SEX AGE (In years IF UNDER 6. COLOR OR RACE 7 MARRIED NEVER MARRIED DATE OF BIRTH Months lost birthdoy) Hours Dovs WIDOWED DIVORCED Oo, USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11 BIRTHPLACE (County & Stote, or foreign country) during mast of working life, even if retired) INDUSTRY **COUNTRY?** tovoice use 13. FATHER S NAME 14 MOTHERS MAIDEN NAME 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no. or unknown) [(If yes give wor or dotes of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Address Husband Same as Item 2. 72-10-0775B Thomas F. Novak cremation, INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)_ by the hospital or attending physicion. DUE TO Conditions, if ony, which gove rise to immediate couse (a), DUE TO stoting the underlying couse as the this certificate has been last. WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) Heolth nullitus NO Y ь 20o. ACCIDENT WAS UNDERLYING [205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port 1 or Port II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Year Hour am. factory, street, office bldg., etc.) Not While O FUNIRAL DIRECTOR: After November 195 8 21. I certify that (I) (this boseital) attended the deceased from_ be retained and that death occurred of 10 52 M, from causes and on the date stated above. saw the deceased alive an 220. SIGNATURE 22b. DATE SIGNED ATTENDING director, page 3 should be filed v 8218 Wisconsin 22d. ADDRESS 22c. PHYSICIAN'S BIAINE TTZGERALD NAME (Type) Bethesda, Maryland 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 230 BURIAL, CREMATION, 23b. DATE THEREOF (County) (Stote) REMOVAL (Specify) Hvattsville. Marvland George Wash. Cemetery 4-22-67 Buria FUNERAL DIRECTOR Bethesda, Maryland VR A15 (4) 20 M 1/66 196



| 3 | , 1 | MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH |
|---|---|--|
| • | death. | 1. PLACE OF DEATH a. COUNTY b. COUNTY b. COUNTY a. STATE b. COUNTY a. STATE b. COUNTY b. COUNTY c. STATE b. COUNTY c. STATE |
| , | after y the ges d | D. CITY OR TOWN (if outside corporate limits, write RURAL end give nearest town) write RURAL and give nearest town) MARYLAND C. CITY OR TOWN (if outside corporate limits, write RURAL end give nearest town) |
| | in by S. Pag | SILVERSPRING 18 DAYS BETHESDA |
| | 24 hours filled in by papers. Pag in 72 hours | d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) A:RUAND NURS: NO HOME OGOO MONTROSE AVE YES NO NO NO NO NO NO NO N |
| | executed within 24 hours af and completely filled in by the remove carbon papers. Fages A. | 3. NAME OF First Middle Last 4. DATE Month Day Year OF |
| | ted w | (Type or print) 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. ACE (in years 1 Funder 1 Year 1 Funder 2 Hast birthday) Months Days Hours Min. |
| | | WIDOWED BY BIVORCED 8/8/9/ Vis. |
| | 10.00 | 10a. USUAL OCCUPATION (Give kind of work done Industry) 12. CITIZEN OF WHAT during most of working life, even if retired) 11. Birt HPLACE (County & State, or fereign country) 12. CITIZEN OF WHAT COUNTRY? |
| | ficate by physici on pleas oval, and | 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME |
| | ath certifi attending ermit. Ther n, or remov | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Daughter Same as Item 2. |
| | death (ne atter permit. ion, or | No 214-32-9536-A Jane O'Donnell |
| | he he sit | PART I. DEATH WAS CAUSED BY: MMEDIATE GAUSE (a) Carebrarance (carebrarance) INTERVAL BETWEEN ONSET AND DEATH |
| | requires that the ding physician. Deen signed by the burial-transit we to burial, cremant to burial, cremant or the burial, cremant or the burial, cremant or the burial or the burial or the company of the burial or the burial | MMMEDIATE GAUSE (a) COLOR OF THE COLOR OF TH |
| | tulres ig ph) en si e bur to bur | Conditions, If any, which gave rise to Immediate (b) Authority to DUE TO |
| | | underlying cause last. (c) |
| | The 1s or att ate h use | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES \(\text{NO} \) NO \(\text{NO} \) |
| | IAN: Pital Pital difficion of Ho | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |
| | ATTENDING PHYSICIA i retained by the hospi ECTOR: After this cer 3 should be detached with the State Dept. or | |
| | ING P I by t After be d State | p.m. 19 at work at work |
| | OR ATTENDI be retained IRECTOR: A ie 3 should sd with the | 21. I certify that (I) (this hospital) attended the deceased from March 23, 1967, to 4, 1967, that (I) (we) last saw the deceased alive on 1967, and that death occurred at March 25, 1967, from the causes and on the date stated above. |
| | OR AT be re JIRECT Se 3 s ed wit | 22a. SICNATURE 22b. DATE SICNED |
| | ITAL I may RAL D RAL D | 22C PHYSICIAN'S |
| | O HOSPITAL OR Page 4 may be O FUNERAL DIR director, page should be filed | BORIS RATISKIN 1019 Continued Car |
| | 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 | Burial 4-18-67 Arlington Natl Cem. Arlington, Virginia |
| | VR A15 (4) | 24. FUNERAL DIRECTOR ADDRESS 250. REC'D BY REGISTRAR 250. RECISTRAR'S SICNATURE ROBERT A. PUMPHREY, Beghesda, Maryland DAPR 17 1967 Iclinia Judge. |
| | 20M 1/65 | DAME IN 1 (1007) |

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05448 CERTIFICATE OF DEATH 35456 PHYSICIAN: The law requires that the death certificate be executed within 24 havrs after death filled in by the funeral PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. COUNTY b. COUNTY o. STATE offer MARYLAND TOWN (If purside carparate imits c. LENGTH OF STAY IN 16 (If outside corporate limits, write RURAL and give negrest town) write RURAL and give nearest town d NAME EF HOSPITAL OR INSTITUTION (If not in haspital, give street address) dapers. d STREET ADDRESS B. IS RESIDENCE ON A FARM? YES NO JA NAME OF First Middle Last DATE Month Dov Year efelv DECEASED (Type or pont) DEATH 10 19 signed by the attending physician and completed burial-transit permit. Then please remave of S SEX 6 COLOR OR RACE 7 MARRIED DATE OF BIRTH AGE (In years IF UNDER I YEAR IF UNDER 24 HRS NEVER MARRIED last birthdoy) Months Dovs Hours WIDOWED DIVORCED 10a, USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12 CITIZEN OF WHAT 11 BIRTHPLACE (County & State, or foreign country) during most of working life even if retired) INDUSTRY Educatar 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME ar remaya WAS DECEASED EVER IN U.S. ARMED FORCES? 16/SOCIAL SECURITY NO (If yes give wor or dates of service) (Yes, na. ar unknawe) CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) INTERVAL BETWEEN ONSET AND DEATH PART I DEATH WAS CAUSED BY (MMED ATE CAUSE (o) be retained by the hospital ar attending physician. DUE TO buriol Conditions, if any, which gave rise to immediate couse (a). DUE TO as the l stating the underlying cause this certificate has been lost WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO BEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) use Health NO for 205 DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 1B.) 20g. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH g detached (IF EITHER, NOTIFY MEDICAL EXAMINER) State Dept. 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame, form, 20c. TIME OF INJURY Month, Day, Year (City or town) (County) (State) Haur a.m. factory, street, affice bldg., etc.) While Not While After at work at wark þe 21. I certify that (I) (this haspital) attended the deceased fram plnous O FUNERAL DIRECTOR: and that death accurred at in Sem, from causes and an the date stated above. 10 ans saw the deceased alive an 19 6 7 22a. SIGNATURE 22b. DATE SIGNED ATTENDING PHYS. M.D. DIRECTOR PHYS. be frimd poge 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) 4740 director, I should be BURIAL, CREMATION, 23b. DATE THEREO! 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (State) (County) REMOVAL (Specify) 250 REC'D BY REGISTRAR VR A15 (4) 20 M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

|) | 05451 | CERTIFICATE | OF DEATH | 05 | 5449 | |
|----|--|--|---------------------------------|---|---|--|
| | 1. PLACE OF DEATH a. COUNTY Mantaernery b. CITY OR TOWN (If cyliside corporaty limits, write RURAL and give nearest town) Chery Chase | MARYLAND c LENGTH OF STAY IN 16 | a. STATE | de corporate limits, write RJRAL and | | |
| | d. NAME OF HOSPITAL OR INSTITUTION (IF not in the Bethesda Nursing | Home | | th st. | e IS RESIDENCE ON A FARM? YES NO | |
| | 3 NAME OF DECEASED (Type or print) S. SEX A. 6 COLOR OF RACE 7 A | A OS 7 MARRIED ₩ NEVER MARRIED 1 8. | TROW 4 | I. DATE Month OF APRIL 9. AGE (In years IF UND | Day Year / 2 19 6) DER 1 YEAR 1 IF UNDER 24 HRS. | |
| | 191 111 | MARRIED NEVER MARRIED 8. MIDOWED DIVORCED DIVOR | 11/30/9 | last birthday) Month | | |
| | during most of working life, even if retired) Purchasing 13. FATHER'S NAME | Construction | Borsdepo: | rt, Conn. | CONTRY? | |
| | Abraham G. Ostrow Sadie M. Mazur Same Forces? (Yes, ng, grunknown) (If yes give wor or dotes of service) 554-16-8607 Allan M. Ostrow (son) | | | | | |
| | IB. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a). Conditions, if ony, which gove rise to immediate cause (a), stating the underlying cause last. (c) | | | | 6 1002. | |
| K. | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTIONS CONTRIBUTIONS OF DEATH OR CONTRIBUTING CAUSE OF DEATH OF EITHER NOTIFY MEDICAL EXAMINER) | | | | 19 WAS AUTOPSY PERFORMED? YES NO | |
| | 20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year | 205 DESCRIBE HOW INJURY OCCURRED. (E | E OF INJURY (Hame, farm, | | (County) (State) | |
| | 20c. TIME OF INJURY Month, Day, Year Haur o.m. 19 21. I certify that (I) (this hospital | While Nat While at work facto | ry, street, affice bldg., etc.) | | , , | |
| | saw the deceased alive on 1967, and that death accurred at 4224 M, from causes and an the date stated above. 22a. SIGNATURE 22b. DATE SIGNED 22b. DATE SIGNED | | | | | |
| 1 | 22c PHYSICIAN'S NAME (Type) William | S. Miller M.D | 22d. ADDRESS | Conn. Ave. N. | w. D.C. | |
| | 230. BURIAL CREMATION, 23b. DATE THEREOF CREMOVAL Specify) 4/12/6" | 7 Lee's Cre | matorium | 23d. LOCATION (City or Town) Washington | | |
| | 24 FUNERAL DIRECTOR Lee Funeral Home | ADDRESS Washington,D | .C. DAPR 1 | y registrar 25b, registrar 4 1967 | S SIGNATURE | |

VR A15 (4) 2⊞ Ⅲ 1/66

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physicar and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours ofter deapt.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the deoth certificate-be executed within 24 hours ofter death

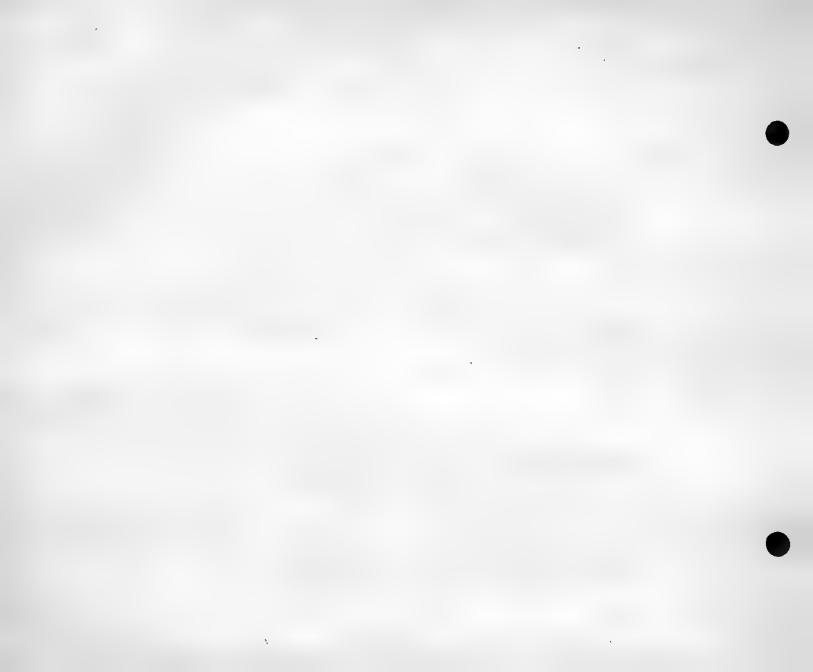
Page 4 moy be retained by the hospitol or attending physician.



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05450 95452 MEDICAL EXAMINER'S CERTIFICATE OF DEATH PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before adparssion) a. COUNTY o. STATE h COUNTY Page delay b CITY OR TOWN (If outside corporate c CITY OR TOWN (f_autside corporate limits, were RURAL and a ve negrest tawn) Wesda d STREET ADDRESS d NAME OF HOSPITAT OR INSTITUTION (If not in Hospital, give street oddress) form Pages hours ofter death. 3 NAME OF Mxdd e DATE DECEASED OF DEATH in Item 18. Give (Type or print) olopa S SEX JE LINDER 1 YEAR 6 COLOR OR BACE MARRIED NEVER MARRIEO AGE (In years b rthdoy) WillOWED OLVORCED. Office (in any event within 72 hours ofter deoth 10b KIND OF BLSINESS OF 12 C TIZEN OF WHAT AL OCCUPATION (Give kind of work dark during most of working life, even if reffred) 13 FATHER'S NAME 14 MOTHER'S MAIDEN NAME be executed within in pencil 17 INFORMAN CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) burnol-transit PART I DEATH WAS CAUSED BY Cardiac. Tain Ponsde IMMED ATE CAUSE (o) writing the word **OUE TO** Rupture of Heart-Conditions, if ony, which gove rise to immediate couse (a). DUF TO stoting the underlying couse Auto Accident. gud 19 WAS AUTOPSY PERFORMED? removol, PART II OTHER SIGNIFICANT CONOIT ONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NAL DISEASE CONDITION GIVEN IN PART 1(0) YES 150 20a EXTERNAL CAUSE WAS PRIMARY X Jr CONTRIBUTING □ 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port I of item 1B) Road-croshed into oncorning Driving Car on Left CAUSE OF DEATH 20e PLACE OF INJURY (Home form. 20f 20c TIME OF NIJRY Month, Oay Year (City or town) (State) foctory, street, office bldg., etc.) Not While of work DIRECTOR: Page Bethesde Nont. Md 21 1 certify that I taak charge at the remains described above, held an Autopsy Inspect on A Inquiry X and in my apinian Natural causes , Accident X Suicide death resulted fram Hamicide Undetermined manner ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER moy be re FUNERAL (SIGNATURE DEPUTY MEDICAL EXAMINER Be thesda, Md. NAME Type! Address (Street city town, or county) the t 23g SIRIAL CREMATION 23b OATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Tawn) 50 Burial (Specify) 4-20-67 St. Paul's Cemetery Laytonsville, Maryland ADORESS 250 REC O BY REG STRAR 25b REGISTRAR S SIGNATURE 24 FUNERAL DIRECTOR VR ATSME Bethesda, Maryland 6M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 35453 CERTIFICATE OF DEATH death 24 hours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) n COUNTY o. STATE b. COUNTY carbon papers. Pages 1 ent, within 72 hours after nt Gomeru MARYLAND b CITY OR TOWN (If autside compfate limits. CLENGTH OF STAY IN 16 c CITY OR TOWN ourside-carporate limits, waite RURAL and give negress write RURAL and give negrest town? in by d NAME OF HOSPITAL OR INSTITUTION (If not in hospito, give street oddress) d STREET ADDRESS IS RESIDENCE ON A FARM? filled 7/ YES NO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within NAME OF DATE Dov Year DECEASED OF 26 None 196 (Type or print) DEATH S SEX IF UNDER TYFAR IF UNDER 24 BRS 7. MARRIED 9. AGE (In years emove any eve **MEVER MARRIED** Inst birthdoy) Months Days Hours WIDOWED DIVDRCED 100. USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BTRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT physician ar ien please oval, and in during most of working life, even if retired) INDUSTRY COUNTRY 2 TAILORISSS - RETIRED TAILORING 13. FATHER'S NAME 14. MOTHER'S MAIDEN MAME ar removal onanno WAS DECEASED EVER IN J S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT permit. (Yes, no, or unknown) (If yes give war or dates of service cremation, 18. CAUSE OF DEATH (Enter only one couse per line for INTERVAL BETWEE signed by the burial-transit PART I DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o) by the haspital ar attending physician. DUE TO Conditions, if any, which gave Cardrovascy rise to immediate couse (a) DUE TO stating the underlying couse ifter this certificate has been be detached far use as the State Dept, at Health prior to last. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(g) NO YES 200 ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port II of item 18.) DR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER MEDICAL 20c. TIME OF INJURY Month, Day, Yeor 20d INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour 'o.m. While Not While foctory, street, office bldg., etc.) at work of work O FUNERAL DIRECTOR: After 21. I certify that (1) (this haspital) attended the deceased fram Jan 1967, that (1) (we) last to April 26 be retained saw the deceased alive an April 26 1967, and that death occurred at 5 12 M, from causes and on the date stated above 22o. SIGNATURE 22b. DATE SIGNED DIRECTOR PHYS. director, page 22c. PHYSICIAN'S NAME (Type) 22d ADDRESS 230 BURIAL, CREMATION, .OCATION (City or Town) (County) REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE VR A15 (4) 25M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05454 CERTIFICATE OF DEATH O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death Page 4 may be retained by the haspital or attending physician. I. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission o. COUNTY p. STATE b. COUNTY Montgomery MARYLAND Virginia Amherst b. CITY OR TOWN (If outside corporate limits, E. LENGTH OF STAY IN 15 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) Bethesda days Amherst d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) & STREET ADDRESS e IS RESIDENCE ON A FARM? filled The Clinical Center, Bothesda, Md. 20014 Box 178 YES NO 🔀 NAME OF DECEASED Lost 4. DATE Month Yeor ond completely OF DEATH event (Type or print) James Edward Pendleton April S SEX 9 AGE (In years 6. COLOR OR RACE 8 DATE OF BIRTH IF UNDER 1 YEAR 7 MARRIED NEVER MARRIED K burial-transit permit. Then pleose remove burial, cremotian, or removal, and in any evi last_birthdoy) Months WIDOWED DIVORCED February 7. Malle Necro 10a USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12 CITIZEN OF WHAT 11 BIRTHPLACE (County & Stote, or foreign country) physicion c nen pleose during most of working life, even if retired) INDUSTRY **COUNTRY?** Virginia Pantry worker College USA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME James L. Pendleton Mary E. Gilmore 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT The Medical Recorddress 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give wor or dates of service) 203-20-0703 The Clinical Center, Bethesda. 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c))
PART I. DEATH WAS CAUSED BY INTERVAL BETWEEN signed by the burnal-transit p DISEJ AND DEATH Corpulmonale, Respiratory Failure (b) Generalized Bronchospasm 4 Days Conditions, if any, which gave : rise to immed ate cause (a). DUE TO Chronic Myelogenous Leukemia Yrs. stoting the underlying cause Wk. ___in Blastic Crisis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS AUTOPSY for us YES NO [Renal Failure. Gastrointestinal Hemorrhage. 20o. ACCIDENT WAS UND€RLYING □ 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour a.m. Not While foctory, street, office bldg , etc) **DIRECTOR:** After 21. I certify that XX (this haspital) attended the deceased fram April 27 , 19 57, to april 30 , 19 57 that XXX (we) lost saw the deceased alive any April 30 19 67, and that death accurred at 6:25 M, from causes and an the date stated above. 220/SIGNALIR 22b DATE SIGNED ATTENDING PHYS STAFF PHYS May 1, 1967 DIRECTOR 22c. PHYSICIAN'S The Clinical Center, National NAME (Type) -David Goldman. Institutes of Mealth, Detherds, Md 23r. NAME OF CEMETERY OR CREMATORY 23o. BURIAL, CREMATION, 23h. DATE THEREOF 23d LOCATION (City or Town) (County) (State) RETOWN 1 Amherst, Va. 24. FUNERAL DIRECTOR ADDRESS 2So REC'D BY REGISTRAR VR A15 (4) 25M 1/67 DATE MAY 5 Rockville, Md Rebert L. Snowden



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item #9 Film #G CERTIFICATE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before commission PLACE OF DEATH a. COUNTY o. STATE b. COUNTY ONTGOMERY MARYLAND haurs after b CITY OR TOWN (If autside carparate imits. c LENGTH OF STAY IN 1b c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) The law requires that the death certificate be executed within 24 haurs ROCKVILLE bon papers. within 72 ha e. IS RESIDENCE ON A FARM? d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS YES. NO POTOMAC VALLEY NAME OF Midd[†]e 4. DATE POOL Last Montb Doy Year DECEASED OF DEATH VERNON OPLES 1967 (Type or print) S. SEX IF UNDER 1 YEAR TIF UNDER 24 HRS 6. COLOR OR RACE DATE OF BIRTH AGE (In years 7 MARRIED **NEVER MARRIED** remove last birthday) Months Hours 90 DIVORCED WIDOWED 12 CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR COUNTRY? during most alworking life, eyen if retired) INDUSTRY physician 13. FATHER S-NAME 14. MOTHER'S MAIDEN NAME ar remaya 15 WAS DECEASED EVER IN U.S. ARMED FORCES? INFORMAN' Address 16. SOCIAL SECURITY NO (Yes, no, or unknown) (If yes give wor or dotes of service) crematian. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) signed by the burial-transit PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) attending physician. DUE TO signed l burial. Conditions, if ony, which gove nse ta immediate cause (a), DUE TO stoting the underlying couse as the prior tal lost. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) has YES I NO ficate the hospital ar 20 a. ACCIDENT WAS UNDERLYING □ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Part II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH certif detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Day, Year Hour am. foctory, street, office bldg., etc.) While Nat While at work ot work 21. I certify that (I) (this hospital) attended the deceased fram. Page 4 may be retained and that death occurred at 3! SAM, from causes and an the date stated above FUNERAL DIRECTOR: saw the deceased alive an 22o. SIGNATUR 22b. DATE SIGNED ATTENDING STAFF DIRECTOR PHYS. page a 22d. ADDRESS O HOSPITAL Scru, J. NAME (Type) director, should t 23a BURIAL CREMATION 23b, DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) REMOVAL (Specify) Harmon/ Memorial xbaxhanxxxxx Lando er. Md. 0 REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66

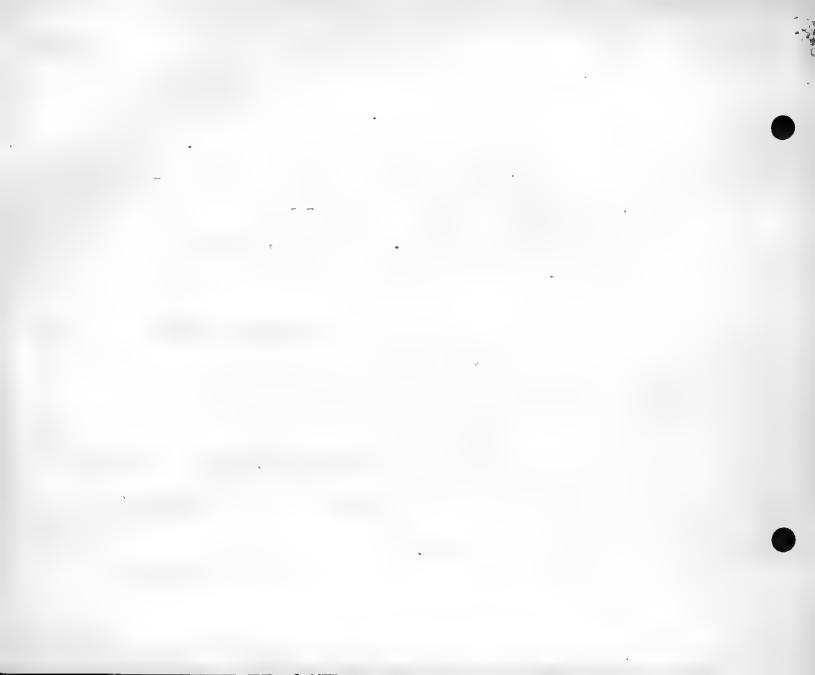


MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 24 hours after death. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, It institution: Residence before admission) a. COUNTY b. COUNTY MONIDOMER MARYLAND CITY OR TOWN/(if outside co-porate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL end give nearest town) SlAdENS SPRING d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? NO . DEL KOA YES ! executed within 3. NAME DE First Middle DATE DECEASED event 2771 DEATH (Type or print) 6. CDLOR OR RACE 5. SEX DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS 7. MARRIED NEVER MARRIED last birthday) | Months | Days Hours WIDOWED ! DIVORCED [10a. USUAL OCCUPATION (Give kind of work done | 10b. KIND DE BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTMPLACE (County & State, or foreign country) sician lease r during most of working life, even (f retired) INDUSTRY COUNTRY? certificate be and (Page Co.) Virginia physic n plea MINOR 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME he attending p permit. Then Barbara McCleary 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT Address 16. SOCIAL SECURITY ND. 5 death (Yes, no. or unknwn) (If yes nive war or dates of service) John A. Pettit Item 2 INTERVAL BETWEEN ONSET AND DEATH 18. CAUSE DF DEATH [Enter only one cause per line for (a), (b), and (c). cremat ed by PART I. DEATH WAS CAUSED BY: attending physician. racrauial MARKET IMMEDIATE CAUSE (a) signed 1 DUE TO buri Cenditions, if any, which been gave rise to immediate 計記 **DUE TO** cause (a), stating the underlying cause last. 38 CERTIFICATION WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION CIVEN IN PART 1(a) for use Health PERFORMED? certificate YES X NO [20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Pert I or Part II of Item 18.) detached f Dept. this (State) 20c. TIME OF INJURY Month, Day, Year 2Dd. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) factory, street, office bldg., etc.) Hour a.m. Not While While at work at work p.m. 9 21. I certify that (I) (this hospital) attended the deceased from DIRECTOR: age 3 should lied with the Z and that death occurred a 8:257M, from the causes and on the date stated above. saw the deceased alive on 227. SICNATURE DATE SIGNED 22b. MED. DIRECTOR M.D. FUNERAL ADDRESS 22d. PHYSICIAN'S director, p NAME (Type 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) BURIAL, CREMATION, 23b. DATE THEREDF REMOVAL (Specify) Stanlev Virginia Graves Chapel บทว์ลโ REC'D BY RECISTRAR | 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS VR A15 (4) 20M 1/65



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 35457 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 115455 FOR STATE HEALTH DEPT 1. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a COUNTY o STATE b COUNTY Page Montgomery Department of use after death. p Marvland MARYLAND Howard b C TY OR TOWN (If autside carparate him ts. c LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside corporate limits, write RURAL and give negrest town) P.M.3. write RURAL and give nearest town) Olney 21shrs. Ellicott City d NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? 42 Evergreen Ave. Montgomery General Hospital Item 18. Give Pages Office alang with for YES | NO A be executed within 24 haurs after death 3. NAME OF Middle the Station (in 1972) last 4. DATE Manth Day Year DECEASED OF 4-14-67 Richard (Type ar print) Lawpence Phelps DEATH 19 1 5 SEX 6 COLOR OR RACE 8 DATE OF BIRTH 9 AGE (In years IF UNDER YEAR IF UNDER 24 HRS 7 MARRIED NEVER MARRIED birthday) Months 守 Days Hours White Male 8-1-45 WIDOWFD DIVORCED event CV. 11 BIRTHPLACE (State or fare gn country) 10a JSUAL OCCUPATION IG Ve kind of work done 10b. KIND OF BUSINESS OR 12 CITIZEN OF WHAT during mast of working life, even if retired) **NDUSTRY** COUNTRY? London, England rd "pending" in pencil in Chief Medical Examiner's pages in any 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Richard J.Phelps Mary Ann Boone and 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, ar unknown) ((If yes give war ar dates of service) remayal, 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c),) INTERVAL BETWEEN **burial-transit** PART I. DEATH WAS CAUSED BY: ExBongustiin. from. Rus Ь IMMEDIATE CAUSE (a) ward s a burial-tro crematian, This certificate shauld DUE TO rooms from Auto Accident farwarded to the Conditions, if ony, which gave rise to immediate cause (a). DUE TO stating the underlying couse used as burial, c PART II OTHER SIGNIFICANT CONDITIONS CONTR. BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) WAS AUTOPSY PERFORMED? NO [20a EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) prior PRIMARY I or CONTRIBUTING I Page 4 shauld Passenger mear-Z CAUSE OF DEATH agent, 20c. TIME OF INJURY Manth, Day, Year 20d INJURY OCCURRED 20e, PLACE OF INJURY (Hame, farm, 20f. (City or town) (State) foctory, street, office bldg. etc.) DIRECTOR: Page Not While larks. Ville Howard NId at wark at work designated 21. I certify that I taak charge of the remains described above, held an Autopsy [X], Inspection A Inquiry A and in my apinian funeral director. Accident X death resulted fram. Natural couses | Suicide 🔲 Hamicide Undetermined manner retained CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER **SIGNATURE** FUNERAL TO DEPUTY DEPUTY MEDICAL EXAMINER ō **EXAMINER'S** may Health (NAME (Type) Address (Street, city, town, or county) 23g. BURIAL, CREMAT ON 23b. DATE THEREOF 23c. NAME OF CEMEDERY OR CREMATORY 23d_LOCATION (City or Town) (Stote) 0 REMOVAL (Specify) ... REGISTRAR'S SIGNATURE 25a REC'D BY REGISTRAR VR A15ME (5) Ochone In Out APR

MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH



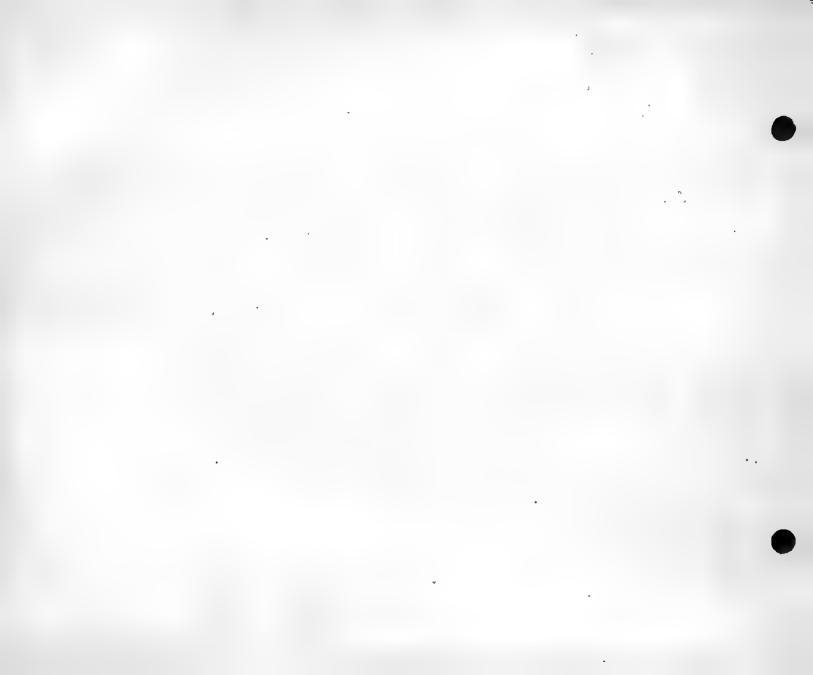
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND FOR STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH HEALTH DEPT. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) Montgomery a. STATE b. COUNTY MARYLAND Department after death, b. CITY OR TOWN (If outside corporate ilmits, write RURAL and give nearest town)
Silver Spring C. LENGTH OF STAY IN 1b c. City OR TOWN (If outside corporete limits, write RURAL and give nearest town) Silver Spring years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS a. 15 RESIDENCE ON A FARM? 211 Springbrook Drive State hours Springbrook Drive NO K YES NAME OF 4. DATE Month Middle Year the 72 DECEASED Virginia Mary ilgrim April 1907 (Type or print) DEATH ifter death. If a Give Pages 1, 2 og with form P 2 with within SEX 6. COLOR OR RACE DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS 7. MARRIED NEVER MARRIED 8. lest birthday) 2-4-1908 Months Days Fe White WIDOWED 2 DIVORCED [and a 10a. USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? Martins Gerry, Ohio & . s.A. Housewife Own home 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME EXAMINER: This certificate should be executed within 24 hound a certificate, writing the word "pending" in pencil in Item should be forwarded to the Chief Medical Examiner" Office Thomas H. Lucy Sedgwick File 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. Address (Yes, no, or unkown) [(If yes give war or dates of service) 10020 Brookmoor Drive Dennis C. None 212-32-1594 Pilarim 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), end (c).] INTERVAL BETWEEN ONSET, AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) burial-transit Pulmonary edema minutes cremation, DUE TO Conditions, if ony, which Smoke inhalation Few minutes geve rise to immediate DUE TO couse (a), stating the rg. underlying cause lest. ed as burial, PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? CERTIFICATION Pulmonary edema 2 2 YES 🔽 NO should be 20a. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part 1 or Pert 11 of Item 18.) PRIMARY 13 or CONTRIBUTING CAUSE OF DEATH. Found in her burned out bedroom 3 shoul agent, 1 MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) factory, street, office bldg., etc.) While Not While at work Not While Silver Spring Mont Md. CTOR: Page designated Inspection Xi, 21. I certify that I took charge of the remains described above, held an Autopsy and In my opinion Inquiry death resulted from: Undetermined manner Natural causes Accident X. Suicide Homlcide CHIEF MEDICAL EXAMINER **ACTUAL** 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE DEPUTY MEDICAL EXAMINER FUNERAL f Health of EXAMINER'S Seminary Address (Street, city, town, or county) please ey director. retained John S. Rogers, M.D.1919 NAME (Type) BURIAL, CREMATION 23b. DATE THEREOF BEMOVAL (Specify) Apr 26, 196 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) 0 0 Hpr 26, Parklawn Cemeteru 1967 29 FUNERAL DIRECTOR homas 1967 A15ME (5) Warner (. Pumphrey, Inc. 1/65



| 1 1 | | 05460 | Division of STATIS | TICAL RESE | MAR | YLAND STAT | E DEI 5. 301 | PARTMENT OF HEA W. PRESTON STREET | LTH '. BALTIMORE, MARY | LAND 2120 | 1 | | | | |
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| (Na. | C | leard by | stonen of | 11/67 | | | | OF DEATH | , | -03 | 5458 | | | | |
| r death |) F | LACE OF DEATH | tgomery | | | MARYLA | ND | 2 USUAL RESIDENCE (Whe | ere deceosed lived, if institu and b. COL | NTY Mont | before odmissio | n) | | | |
| ors after bages burs afte | | b CITY OR TOWN (If actside corporate limits, write RURAL and give negrest town) | | | | | | c. CITY OR TOWN (If outside Silver | de corporate limits, write Rt | IRAL and give n | earest town) | | | | |
| The law requires that the death certificate be executed within 24 hours after attending physician. Has been signed by the attending physician and campletely litted in by the se as the burial-transit permit. Then please remaye carbon gapers pages the priar ta burial, crematian, ar removal, and in any event, within the hours after the contractions of the contractions. | d | 12501 P | at or institution (if a marell mi | ot in hospital, | give str | reet address) | | d STREET ADDRESS | mall Drive | | e, IS RESID ON A FA YES | DENCE ARM? NO [][| | | |
| within arbon gurth, within gurthout gurthout gurthout gurth, within gurth gurt | | IAME OF DECEASED Type or print) | | irst ecinono | | Middle K. | Fi | lost 4 | DATE Mor | # 11 | Doy Yeo | 67 | | | |
| executed with | 5 5 | EX LC | 6 COLOR OR RACE | 7 MARRIED WIDOWED | | NEVER MARRIED DIVORCED | | uly 16, 191 | 9. AGE (In years lost birthdoy) 56 yrs | | | Min. | | | |
| icate be exer please rema II, and in any | duri | USUAL OCCUPATION og most of working e Chanic | (Give kind of work done life, even if retired) | | KIND OF INDUSTR | BUSINESS OR Y | 11 BIRTHPLACE (County & S | tate, or foreign country) | COUN | 27, 19 67 EL YEAR IF UNDER 24 HRS. | | | | | |
| ie death certificate b attending physician permit. Then please ian, ar removal, and | 13. | FATHER'S NAME | Unkno | wn | | | 14. MOTHER'S MAIDEN NAM | | nown | | | | | | |
| death c tending mit. T | 15 (Yes | WAS DECEASED EVE , na, or unknown) | R IN U.S. ARMED FORCES? (If yes give wor or dotes | of service) | . SOCIAL | . SECURITY NO | en - | NFORMANT dvs A. Piot: | Add rowski – wi | | ome it | ×15. | | | |
| at the at the assit per | | | EATH (Enter only one collin WAS CAUSED BY: IMMEDIATE CAUSE | | or (o), (t | b), and (c).) | te | ver Hearb | Film | | | | | | |
| equires that the death certific physician. signed by the attending physi burial-transit permit. Then p burial, crematian, ar removal, | | Conditions, if ony, | which gove) | TO 7 | 171 | pertining | رمز: | artenore | But Heo | A line | 241 | on | | | |
| e law requestions by the property of the property of the property of the property of the prior to by | | rise to immediat stating the under last. | | (c) | 7 | | | | | | | | | | |
| | ATREE | PART II. OTHER SI | GNIFICANT CONDITIONS | CONTRIBUTING | TO DEA | ATH BUT NOT RELAT | ED 10 1 | HE TERMINAL DISEASE CONDI | TION GIVEN IN PART I(a) | | 19 WAS AUTO PERFORM YES | DPSY ED? NO | | | |
| PHYSICIAN: e haspital ar his certificate stached for us Dept. of Healt | CERTIFIEATIE | 20o. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port 11 of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | | | | |
| JING PHYSICIAI by the haspital frer this certifice be detached fa State Dept. of H | EDICAL | 20c. TIME OF INJU Hour o.n | JRY Month, Day, Year n. 19 | Whil | | OCCURRED 2 Not While ot work | Oe. PLA | CE OF INJURY (Home, form, ory, street, office bldg., etc.) | 20f. (City or town) | (Coun | lY) (| (Stote) | | | |
| TENDING ined by th DR: After t auld be do the State | | saw the d | fy that (I) (the he eceased alive an_ | spital) after | nded 1 | the deceased fr | om nd tha | 3/25,19 t death occurred of 6 | 67, to grad 2.50 AM, from causes | and on the | | e) las d obove | | | |
| OR AT be reta DIRECTO ge 3 sho led with | | 22o. SIGNATURE | Muhat. | 1600 | -br | rilgi | M.I | D. PHYS 🔼 DI | RECTOR PHYS. | 22b DAT | 127,19 | 67 | | | |
| TAL AL Page Page e fi | | ZZc. PHYSICIAN'S NAME (Type | Michael Michael | | bri | dre | | 22d. ADDRESS 1260./ P | nkl iri | | | 4 4 4 4 | | | |
| TO HOSPI Page 4 n TO FUNER director, shauld b | | REMOVAL (Specify | 5/1/ | EREOF | | Porkla n | | | 23d. LOCATION (City or I Silver Sp LY REGISTRAR 28b | | [ounty] (S Monstyne BNATHER | itote) r.d. | | | |
| VR A15 (4) | 24 | on ha | R eler Funer | al Hor | me | ADDRESS 1331 at | oci. | | 1 1967 2 | liarla | Judge | • | | | |



| 4 1 1 | tem 18 Film 390 6-22-67 MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 2120/15 450 |
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| FOR STATE | 05461 MEDICAL EXAMINER'S CERTIFICATE OF DEATH |
| HEALTH DEPT. S and 3 to PM3. Page 1.00 to PM3. P | D CITY OF TOWN (If outside carparate limits, LENGTH OF STAY N 1b C |
| - cd 3-62 p | d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) 13924 MARIANNA DRIVE 5024 Jewnsen Utay 13934 Manth OF 13934 Man |
| d within 24 haurs after death life in pencl in Item 18 Give Pages 1, Examiner's Office along with farm File pages Land 2 with the State Deand in any every within 72 hours | DECEASED (Type or print) S SEX O GOLOR OR RACE O MARRIED NEVER MARRIED DIVORCED |
| within 24 ha n pencl in Ite Examiner's Of File pages lai and in any ev | 13. FATHER'S NAME Virgil W. Potts Dist. OF COL. COLITY'S, A. 14. MOTHER'S MAIDEN NAME LIZZIE J. BARTON |
| be executed 'pending'' in hief Medical E. ansit permit. F | S WAS DECEASED EVER IN J.S ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT Eather U. Address 118 Alleghaney R 18 June 2 13 - 40 - 9694 WANTER PORT TS XXXX Manassas, Ua |
| ate should be of the ward pe of to the Chief of bural-transi | CAUSE OF DEATH (Enter only one touse per line for (o), (b) and (c)) PART I DEATH WAS (AUSED BY IMMEDIATE CAUSE (o)) TX X Conditions, if ony, which gove rise to immediate couse (o), storting the underlying couse last. (c) Conditions of the underlying couse last. |
| his certificate writing the forwarde be used as ta burial, a | PART II. OTHER SIGN FICANT CONDITIONS CONTR BLTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 19 WAS AJTOPSY PERFORMED? YES NO |
| MINER: the certifi 4 shauld l ur files ie 3 should igent, pria | 20c TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, 120) (City or town) 7 (County) (State) 91 Hour of 4-23 1967 While of work of |
| | death resulted from. Natural causes Accident , Suicide , Hamicide Undefermined manner . ACTUAL SIGNATURE M.D. ASSTANT MEDICAL EXAMINER . 22. DATE SIGNED |
| TO DEPUTY necessary, the funera 5 may be TO FUNERA Health ar | NAME (Type) SELDEN (FAP) 10 Address (Street Street |
| VR A15ME (5) 6M 1/66 | 24 FUNERAL D'RECTOR July Stephens 8434 Georgia Avenue DATE PR 27 1867 Glarles Judges |



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 05462 The law requires that the death certificate be executed within 24-hours after death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) p. COUNTY MONTGOMERY MARYLAND b. CITY OR TOWN (If outside carparate limits, E LENGTH OF STAY IN 16 c CITY OR TOWN (If gutside carparate | mits, write RURAL and give nearest tawn) (RURAL) on BETHESDA" 5 DAYS 6200 OREGON AVENUE N.W. d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS IS RESIDENCE within 72 ON A FARM? ARMY DISTAFF HALL U.S.NAVAL HOSPITAL, BETHESDA, MD. YES NAME OF First Middle 4. DATE Manth completely Year DECEASED KATHERINE PRIEST APRIL and in ony event, 26 (Type or print) DEATH S. SEX 6. COLOR OR RACE IF UNDER 1 YEAR IF UNDER 24 HRS 9. AGE (In years 7. MARRIED B. DATE OF BIRTH NEVER MARRIED birthday) Manths Hours JAN 31, 1885 CAUC. FEMALE WIDOWED DIVORCED and 10a USUAL OCCUPATION (Give kind of work dane 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or fareign country) 12 CITIZEN OF WHAT during most of working life, even if retired)
HOMEMAKER pleose INDUSTRY COUNTRY? ST. JOSEPH. MISSOURI U.S.A. 13. FATHER S NAME 14. MOTHER'S MAIDEN NAME or removo DEC'D ROBERT W. DOWDY DEC'D) ANNIE CLARKSON IS. WAS DECEASED EVER IN U.S. ARMED FORCE S? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes no, or unknawn) (If yes give war or dotes of service) 229 60 0334 NAVY RECORDS USNH BETHESDA. MARYLAND IB. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c)) INTERVAL BETWEEN signed by the burial-tronsit PART I DEATH WAS CAUSED BY: ONSET AND DEATH ARTERIOSCHLEROTIC CARDIOVASCULAR HYPORINONS IVE. IMMEDIATE CAUSE (a) DUE TO DISEASE Canditions, if any, which gave (b) rise to immediate cause (a), DUE TO stating the underlying couse os the prior to certificate hos PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY PERFORMED? Health 1 NO 20a ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Part I or Part II of Item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, (City or town) (Stote) (County) Hour a.m. foctory, street, affice bldg., etc.) at wark at wark , 19___, that (I) (we) last 21. I certify that (I) (this haspital) attended the deceased fram 19 , ta TO FUNERAL DIRECTOR: saw the deceased alive an and that death accurred at__ M, fram causes and an the date stated above. 22a_SIGNATURE 22b. DATE SIGNED STAFF PHYS. APRIL 27, 1967 MD DIRECTOR PHYS R. FOREMAN D. BETHESDA, MARYLAND NAME (Type) 23b. DATE THEREOF 23a BURIAL CREMATION. 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (State) (County) 5-1-67 ARLINGTON NAT. CEMETERY ARLINGTON. VIRGINIA 24 FUNERAL DIRECTOR **ADDRESS** 2Sq. REC'D BY REGISTRAR 2Sb REGISTRAR'S SIGNATURE VR A15 (4) 25M 1/67 R.A. PUMPHREY 7557 WISCONSIN AVE. BETH. MD.

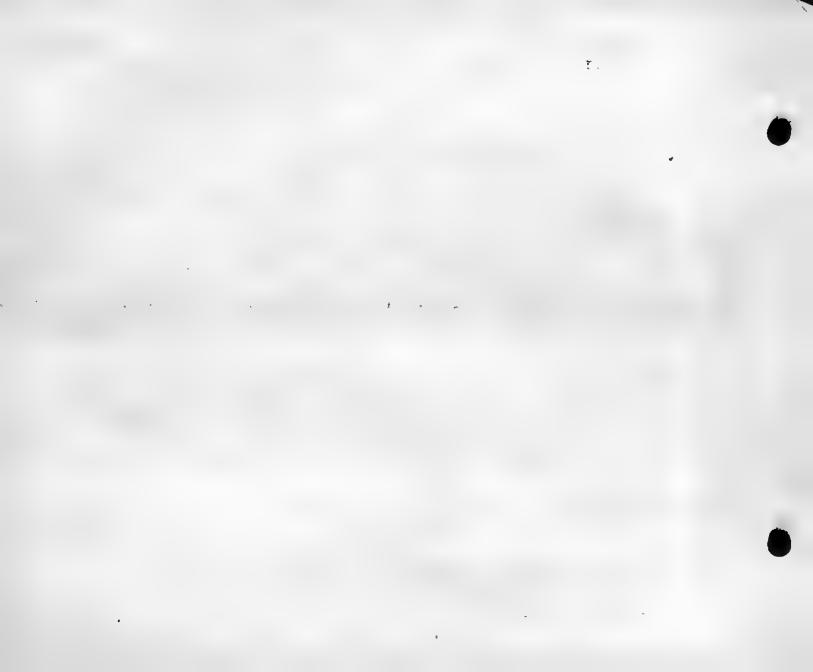


Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05463 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a COUNTY o. STATE **b** COUNTY ONTEOME MARYIAND c. LENGTH OF STAY IN 16 c CITY OR TOWN (If outside carparate, firmits, write RURAL and give nearest town) b CITY OR TOWN (if autside corporate limits, write RURAL and give nearest town nsingtor the attending physician and completely filled in by sit permit—then please remove carban papers. P remaye carban papers. Prany myent, within 72 hau d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS ON A FARM dens YES NO X NAME OF Middle 4 DATE Day Year DECEASED (Type or print) OF DEATH 1967 im IF UNDER 24 HRS AGE 6. COLOR OR RACE In years 7. MARRIED NEVER MARRIED DATE OF BIRTH birthday) Months Days Hours **WIDOWED** DIVORCED 10o. USUAL OCCUPATION (Give kind of work dane 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or fareign country) and in during most of working life, even if retired) COUNTRY? INDUSTRY S. Housewife 13. FATHER S NAME 14. MOTHER'S MAIDEN NAME burial, crematian, ar remaval Henry Davidson Marv 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, ar unknown) [(If yes give war or dates of service] 54908 Augusta St. 17. INFORMANT Charles Washington. INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line far_(a), (b), and (c) signed by the burial-transit p PART I, DEATH WAS CAUSED BY EMMEDIATE CAUSE (a) DUE TO Conditions if any, which gave rise to immediate cause (a), DUE TO stating the underlying cause Page 4 may be retained by the hospital or attending as the prior to has been last. use as PART II. QIHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART-1/01 WAS ALTOPSY PERFORMED? NO O FUNERAL DIRECTOR: After this certificate 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I ar Part If af item 18) 20g ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH be detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Home, form, (City or town) (Stote) 20c. TIME OF INJURY Manth, Day, Year 20d INJURY OCCURRED (County) Hour a.m. factory, street, affice bldg , etc.) Not While Whife at wark at work 2). I certify that (1) (this hospital) attended the deceased fram July 196/ ta APRICIS ___ 1967, that (I)_(swe) last , and that death accurred at 3:50 PM, fram causes and an the date stated above saw the deceased alive and 22b. DATE SIGNED 22a, SIGNATURE ATTENDING PHYS MED. DIRECTOR 4-18-67 director, page 3 should be filed v M.D. PHYS 22d ADDRESS 22c. PHYSICIAN'S-NAME (Type) 23o. BURIAL CREMATION 23b. DATE THEREOF NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) REMOVAL (Specify) 4-20-67 Cedar Hill Crematory Suitland, Maryland on **ADDRESS** 24. FUNERAL DIRECTOR VR A15 (4) PUMPHREY, Bethesda, Maryland 20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W, PRESTON STREET, BALTIMORE, MARYLAND 21201 35464 CERTIFICATE OF DEATH 05462 PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution. Residence before admiss on o. COUNTY A b. CQUNTY MARYLAND c LENGTH OF STAY IN 1b c. CITY OR TOWN outs de corparate limits, write RURAL and give nearest town) requires that the death certificate be executed within 24 hau INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e IS RESIDENCE ON A FARM? Te HOSPITAL YES NO X NAME OF Middle DATE Doy Yeor DECEASED 196 (Type or print) DEATH MARRIED DATE OF BIRTH LE JNDER 1 YEAR IF JINDER 24/HRS **NEVER MARRIED** lost birthdoy) Months Dovs Hours remay WIDOWED DIVORCED physician and Do USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 12 CITIZEN OF WHAT Contractor COUNTRY? 13. FATHER'S NAM 14 MOTHER'S MAIDEN cremation, or removal, Louise Cline 16. SOCIAL SECURITY NO 17 INFORMANT (Yes, no, or unknown) (If yes give war or dates of service Nο 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c),) INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o) DUE TO signed | burial-tr burial, c Conditions, if ony, which gove rise to immediate cause (o), DUE TO stoting the underlying couse Inst PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) WAS AUTOPSY PERFORMED? NO 200 ACCIDENT WAS UNDERLYING [7] 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 2De. PLACE OF INJURY (Home, form, 2Dc TIME OF INJURY Month, Doy, Year 2Dd INJURY OCCURRED 20f (City or fown) (County) (Stole) Hour o.m. factory, street, office bldg, etc.) While Not While of work ot work O FUNERAL DIRECTOR: After 21. I certify that (1) (this hospital) attended the deceased from 19 6.7. that (1) (-we) last saw the eleceosed alive an and that death accurred at 3 M, from causes and an the date stated abave 220 STGNATURE 22b DATE SIGNED ATTENDING directar, page 3 shauld be filed v M.D. PHYS DIRECTOR 224. PHYSIC ANS 22d ADDRESS NAME (Type Hugh Trev 105 230 BURIAL, CREMAT ON 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) Bur La Specify) 4-12-67 Bethel Church of God Fred. Cascade. Md. 24. FLINERAL DIRECTOR 250. REC'D BY REGISTRAR Raymond



| 1 | MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND |
|---|--|
| £ ₽0₹ | 05463 CERTIFICATE OF DEATH 05463 |
| er death. | 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission a. STATE b. COUNTY MARYLAND MARYLAND MARYLAND MARYLAND |
| after after | b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) |
| 24 hours 24 pours papers. Papers in 72 hours | d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENC ON A FARM? |
| . Variable | 11006 Kenilworth Avenue YES NOK |
| uted withii completely vve carbon event, wit | OF (Type or print) Jane Carroll Putnam DEATH April 8 19 67 |
| executed within and completely remove carbon any event, with | 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years last birthday) Hours Min Wildowed Wildowed Divorced 7eb 24, 1883 84 yrs. |
| | 108. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR line working life, even if retired) 11b. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? Who home 11c. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? Urginia |
| certificate be ending physician and Then please removal, and in | 13. FATHER'S NAME John 9. Gouldman 14. MOTHER'S MAIDEN NAME Alma Smith |
| aw requires that the death certificate be the death certificate be than been signed by the attending physiciar as the burial-transit permit. Then please prior to burial, cremation, or removal, and in the street of the burial companies. | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unkown) (If yes give war or dates of service) 217-05-9512-D Jane C. Putnam Garrett Park Maryland |
| t the d an. I by the ansit p remation | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Section 2.2.2.2.2.2.2.2.2.2.2.2.2.2.2.2.2.2.2. |
| The law requires that the or attending physician, ate has been signed by tuse as the burial-transit alth prior to burial, creman | Conditions, if any, which DUE TO |
| law requirently tending the peer as the prior to | gave rise to immediate cause (a), stating the underlying cause last. (c) SQN117 - G. 84 |
| t: The la tal or att fificate ha for use a Health p | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO HETERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPS' PERFORMED? YES NO PERFORMED? YES NO PERFORMED? |
| PHYSICIAN: The latter the hospital or at this certificate detached for use the Dept. of Health | 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.) |
| DING PHY and by the After this d be deta d State De | 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, Pum. 19 at work at |
| | 21. I certify that (i) (this hospital) attended the deceased from 19, and that death occurred at M, from the causes and on the date stated above |
| 4 2 0 0 | 223. SIGNATURE M.D. ATTENDING MED. STAFF 22b. DATE SIGNED M.D. PHYS. DIRECTOR PHYS. |
| PITAL 4 ma 6 ma or, pa | 22c. PHYSICIAN'S NAME (Type) SAM ALLEN, M. D. 22d. ADDRESS Konsington |
| Page Page O FUN direct | 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) |
| ₩ ₩ WR A15 (4) | Rusiai Hor 12, 1967 Arlington Nat 1 Cemetery Arlington Virginia 24 FUNERAL DIRECTOR Warner E. Funghrey, 9nc. 8434 Georgia Avenue DAPR 12 1967 Yellarles Judge. |
| 15M 4-64 | warner (. Pumpriney, Inc. Silver Spring Md DAG R 12 1361 1 |



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05466 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DEPT 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) any delay is 1, 2, and 3 ta n PM3. Page p. COUNTY o. STATE b. COUNTY MARYLAND b. CITY OR TOWN (If outside corporate I mits, c. LENGTH OF STAY IN 16 t CITY OR TOWN AT autside carparate limits write RURAL and give nearest town) write RURAL and to ve negrest fown) e IS RESIDENCE d. NAME OF HOSPITAL OR INSTITUTION (If not inchospital, give street oddress) d STREET ADDRESS e certificate, writing the ward "pending" in pencil in Item 18. Give Pages 1, should be farwarded to the Chief Medical Examiner's Office along with farm Dies YES NO X in Item 18. Give Pages NAME OF Middle First DATE Day Year DECEASED with The DEATH (Type or pnnt) IF JNDER AGE (In ears SEX 6 COLOR OR RACI 7 MARRIED NEVER MARRIED -dest burthdoy) Months Doys Hours WIDOWED DIVORCED in any event within 72 haurs after death 100 JSUAL Of CUPATION (Give kind of work done 10b KIND OF BUS NESS OR BIRTHPLACE (State of foreign country) 12 CITIZEN OF WHAT during most of working life, eyen if retired) INDUSTRY, 13 FATHER'S NAM 14 MOTHER'S MAIDEN NAME be executed within Rose M. aldamany WESH, DE IS WAS DECEASED EVER NUS ARMED FORCES 17. INFORMANT 16 SOCIAL SECURITY NO (Yes, na, or unknown) (If yes give wor or dates of service) WWII 18. (AUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Congestiva IMMEDIATE CAUSE (o) This certificate shauld 140 DUE TO Pericarditis- old + Recent Conditions, if ony, which gove rise to immediate couse (a), DUE TO stating the underlying couse and last. used 19 WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTR BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDIT ON GIVEN IN PART 1(o) remayal, CERTIFICATION YES 💢 NO be 200 EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of njury in Port I or Part II of tem 18.) 3 shauld PRIMARY I or CONTRIBUTING **CAUSE OF DEATH** 20d NIJRY OCCURRED 20e PLACE OF INJURY (Home, form, 20f (City or town) (County) (Stote) 20c TIME OF INJURY Month, Doy, Year factory, street, office bldg , etc) Hour o.m. While Not While of work at work Inspection N Inquiry X 21. I certify that I took charge of the remains described above, held an Autopsy 🙉 ond in my opinion may be retained far FUNERAL DIRECTOR: Notural couses . Accident . Suicide 1 funeral directar. deoth resulted from. Homicide Undetermined monner CHIEF MED CAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER prior SIGNATURE DEPUTY MEDICAL EXAMINER TO DEPUT **EXAMINER'S** 5 may ro FUNE Health Address (Street, city, town, or county) NAME (Type 23b DATE THEREOF 23r. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) 230 BURIAL CREMATION, (Stote) Gate of Heaven Cem Silver REC'D BY REGISTRAR Sons. Melineles VR A 15ME (5) os enh 6M 1/67



W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral should, hours after PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission a. COUNTY a. STATE b. COUNTY Montg Montgomery the d 2 MARYLAND and b. CITY OR TOWN (if outside corporate limits, C. LENGTH OF STAY IN 15 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give neerest fown) Gaithershurg Gai thereburg ST d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS . IS RESIDENCE ON A FARM? 35 S. Summit Ave YES NO petno 3. NAME OF First Middle Lasi DATE 4. Month Year DECEASED OF (Type or print) James Gilbert Reid ã DEATH Apr 190 event, within COL carbon 6. COLOR OR RACE 7. MARRIED THEYER MARRIED 5. SEX 8. DATE OF BIRTH 9. AGE (In years LIF UNDER 1 YEAR) IF UNDER 24 HRS and last birthday) Months Male Wnite Nov WIDOWED [death certificate certificate has been signed by the attending physician please remove 10a. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foraign country) 12. CITIZEN OF WHAT COUNTRY done during most of working life, even if retired) US any Ret. Co. Boyd Md Emo 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 2, and Debrah Burdette James A. Reid 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. | 17. INFORMANT law requires that the Address removal, (Yas, no, or unkown) | (Ifyasgivewarordatasofsarvica) Gaithersburg. Ri chard Reid permit. the hospital or attending physician. 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). INTERVAL BETWEEN ONSET AND DEATH 5 PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cremation, **burial-transit** votic Conditions, if any, which gave rise to immadiata cause **DUE TO** (a), stating the underlying burial, causa last. the PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY CERTIFICATION 35 PERFORMED? use prior NO 20a. ACCIDENT WAS JNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of itam 18.) OR CONTRIBUTING IT CAUSE OF DEATH be retained by the ICTOR: After this DIRECTOR: Affer time (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Homa, farm, 1 20f. (City or town) (County) (State) factory, street, office bldg., atc.) While Not While Hour a.m. ö at work at work p.m 21. I certify that (I) (this hospital) attended the deceased from. saw the deceased alive on. and that death occurred at ... M, from the causes and on the date stated above 22a. SIGNATURE 22b. DATE ATTENDING MED STAFF SIGNED rector, page 3 death. Page 4 PHYS. DIRECTOR PHYS. HOSPITAL 22d. ADDRESS PHYSICIAN'S NAME (Typa) Gaithersburg Jack Schumacher Md 23a, BURIAL, CREMATION, 23b, DATE THEREOF 23c, NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, fown or county) (State) REMOVAL (Spacily) A FO Bovd 24 FUNERAL DIRECTOR'S SIGNATURE REC'D BY REGISTRAR **ADDRESS** aithersburg.ma. VR A15 (4) 20M 5-63



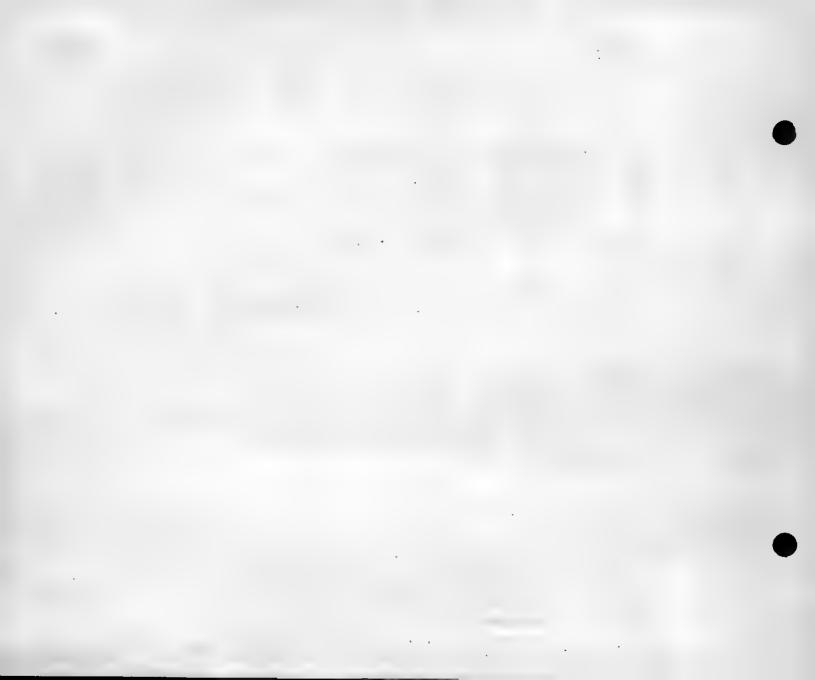
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

| | 954 | 168 | | | CER | TIFICATE | OF | DEATH | | | | Ω | 54 | 66 | |
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| H | 1 PLACE OF D | EATH | | | | | 2 USUA | L RESIDENCE (V | Where dec | eosed lived, | if institution | Residenc | e befare | admissioi | n) |
| | a. COUNTY | COMPART | | | | LADVIANO | o. STA | | , | | b. COUNTY | | | | |
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| | write RU | RAL and give near | asporare rimir est tawn) | 5, | | | 1 (31) | R TOWN (If au | itside corpo | arate rimits, | Write KUKAL | . ana give | negrest | rawn) | |
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| /- | 3. NAME OF | 111 0 11 175 | | rst | Middle | الما | | ost | 4 DATI | | Month | | Day | Yeo | |
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| | (Type or pri | | | 2 101 - 01-0 | Henry | | Rhine | DIOTH | DEAT | | nril. | E HAIDED 1 | 23 | 19 | 67 34 505 |
| | S. SEX | 6. COLOR | OR RACE | 7. MARRIED | NEVER MAR | RIED | B. DATE OF | BIR/H - 11 | -92 | 9 AGE (In lost bin | | FUNDER 1 | Days | IF UNDER Hours | Min. |
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| | duling most sta | yarking life, evenut | Tefiled) | Goul | DUSTRY | na Ott | l w | arvlan | ۵ | | | | INTRY? | | |
| i | 13. FATHER'S N | IAME | | P | | - U U | | HER'S MAIDEN N | | | | Mills | - 11 C | 2.7 | |
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| | no | | ne | | <u>0-11/1-015</u> | 14 1 1 1 | EXXXX | or action of | MOONE | 34 | ver S | ptin | a. 1 | id. | |
| | 1B. CAUS | E OF DEATH (Enter | only one cou | ise per line for | (o), (b), ond (c).) | | | | | | | | | RVAL BETY | |
| | | I. DEATH WAS CA | USED BY. EDIATE CAUSE | (a) | Canal | beros s | 1 +/4 | Ponce | real | | | | OW? | ET AND DE | AIM |
| | 1 | 7.5 | DUE | * * | | - (| - | , | | | | | | | |
| | | , if any, which gas | | (b) | | | | | | | | | | | |
| | | mediote couse (c | | | | | | | | | | | | | |
| | stating the | underlying cou | ie . | (c) | | | | | | | | | | | |
| | | THE SHOULD SHE | COMPITIONS C | | TO DELTH OUT NOT | DELATED TO | DIE TEDALIN | AL DICTACE COL | DITION | INCH IN DAD | T 2/-3 | | 10 | WAS AUTO | DCV |
| | S PART II. U | INEK SIGNIFICANT | כמאטווומאט כ | ONIKIBUTING | TO DEATH BUT NOT | KETATED IO | IHE TERMIN | AL DISEASE CON | VUITION G | IVEN IN PAK | 1 1(0) | | | PERFORME | D? |
| | \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\ | | | | | | | | | | | | YE | S 1 | 40 X |
| | | ENT WAS UNDERLYI BUTING 🗀 CAUSE C | | 205. DE | SCRIBE HOW INJUR | Y OCCURRED. | (Enter notu | re of injury in I | Part I or F | Port II of iter | n 18.) | | | | |
| | | NOTIFY MEDICAL EX | | | | | | | | | | | | | |
| | 20c. TIME | OF INJURY Manth | , Doy, Year | | NJURY OCCURRED | | | RY (Home, farm | | . (City or | tawn) | (Cau | nty) | (5 | state) |
| | WEE . | our o.m. | 19 | While at war | | → fact | ary, street, (| office bldg., etc.) | | | | | | | |
| | 21 | | I) (this her | | ded the deceas | ed from | Tan | 1 | 962 | to A. | × 2 /3 | 19.6 | 7 th | nt /I) (v | اما امیا |
| | snw | the deceosed | olive on | 1000 | 1967 | and the | t death | occurred of | 12306 | M. from | rouses an | d on th | e date | stated | ohove |
| | 22a, SIGI | | 01110 011_2 | -0 | | | | | | | | 22b. DA | | | |
| | | | U Ko | the | MD. | MI | ATTEN D. PHYS | DING 🖽 | MED DIRECTOR | ST/ | VFF | | 13. | | |
| | 22c, PHY | SICIAN'S | | | 1 | Misi | , | ADDRESS | | | | | | | 1 |
| | | IE (Type) | R.H. | Sanch | א המנידרי | וכויו | | 7701 | Car | roll F. | Nc - | Tan Kan | 4 00 | in K, II | 110 |
| | 22- Dilnier C | THITION I | 7.5.7 | | 23c. NAME OF | CEMETERY OR | CDCMATOO | | | | |) | Country | ir. | -4-1 |
| | 23a. BURIAL, CI REMOVAL | (Sperify) | 236 DATE TH | | | | | | | LOCATION (C | • | | (County) | (2) | ote) |
| | 5 11 MAGA | - 1 | goril, | 1. 2 7 A | 57 Rock (| reek (| emete | | | shinas | | 7701016 | 0.0147110 | - | |
| | 74. FUNERAL | OIKEETOR JOINGS | - the | Chima | 134 Gen | rgia A. | jenue | 2So. REC'D | | | 25b, REGIS | STRAR'S SI | | 2.00 | |
| | Bahnon | Dunh | MOU 1 | 10 C | . 1 | a. | MI | L MARTIN | 1 / | 1967 | YUU | CHYCL | 1 14 | Contraction of the last | |

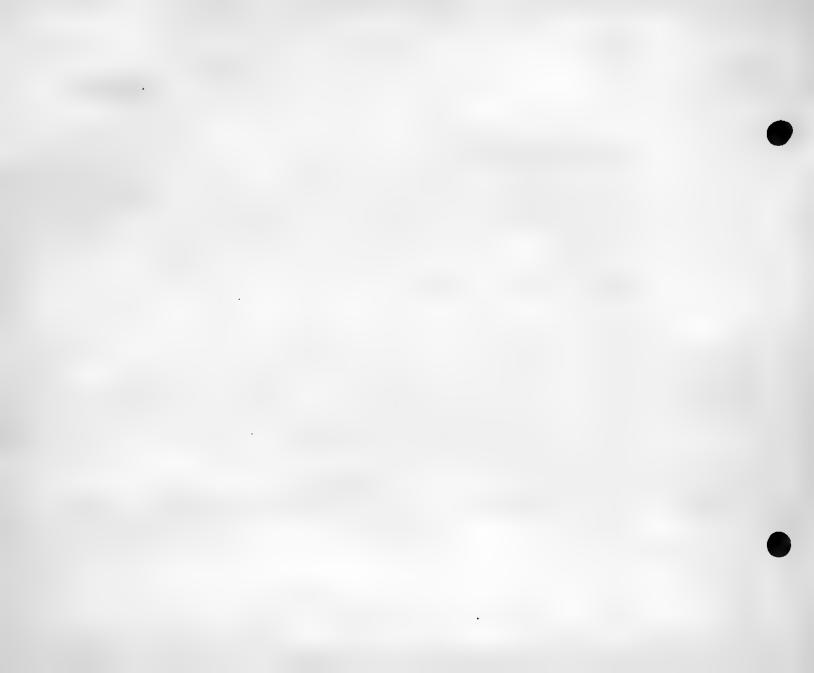
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corbon-papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 22 hours offer defilin. VR A15 (4) 20 M 1/66

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours ofter death.

Page 4 may be retained by the hospital or ottending physician.



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 35469 CERTIFICATE OF DEATH in by the funeral ers. Pages 1 and 2 2 hours ofter death. O COUNTY USUAL RESIDENCE (Where deceosed lived, if institution Residence before odmission) o. STATE b. COUNTY Montgomers MARYLAND b CITY OR TOWN (If outside corporate limits, c CITY OR TOWN (If outside corporate limits, write RURAL of digite nearest town) C LENGTH OF STAY, IN 16 write RURAL and give neares (town) The law requires that the death certificate be executed within 24 hours Clayo Takoma Par d. NAME OF HOSP TAL GR INSTITUT DN (If not in hospital, give street address) d STREET ADDRESS e IS RESIDENCE File 72 ON A FARM? YES NO die W NAME OF Lost 4 DATE Year DECEASED (Type or print) Rice 1967 DEATH Apri phemia 6 CDLOR QR RACE AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 7 MARRIED **NEVER MARRIED** B. DATE OF BIRTH remove lost birthdoy) Months Doys Hours and in ony WIDOWED DIVORCED 10-2 whi 100 JSUAL DCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & Stare, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY CDUNTRY? Maryland House wite 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME signed by the attending physi burial-trans't permit. Then pl burial, cremation, ar removol, Mary Jones Harry WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. Address (Yes no prunknown) (If yes give wor or dates of service) Records. washington 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN PART I DEATH WAS CAUSED BY. Tatic IMMEDIATE CAUSE (o) 4000 DUE TO Conditions, if any, which gove rise to immediate cause (a), DUE TO stating the underlying couse hos been lost PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1601 WAS AUTOPSY PERFORMED? NO 200 ACCIDENT WAS UNDER YING DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of Item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME DF INJURY Month, Day, Year 20d INJURY DOGURRED O FUNERAL DIRECTOR: After this 20e PLACE OF INJURY JHOME, form. (City or town) (County) (Stote) factory, street, office bldg., etc.) Hour o.m. Not While 21. I certify that (1) (this hospital) attended the deceased from be retained director, page 3 shaurd should be filed with the _saw the deceosed alive on. 19/01 and that death accurred at 23 M, fram causes and an the date stated above 220 SIGNATURE 22b DATE STGNED DIRECTOR 22d. ADDRESS 22c PHYSICIAN'S Page 4 moy MORSE NAME (Type) 230. BURIAL, CREMAT ON, 23b DATE THEREOF FUNERAL DIRECTOR VR A15 (4) 25M 1/67



DIVISION OF STATISTICAL RESEARCH PRESTON STREET, BALTIMORE 1, MARYLAND OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if Institution: MARYLAND b. CITY OR TOWN (if outside corporeta limits, c. LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporete limits, executed within 24 OSPITAL OR INSTITUTION (if not in haspital, give street eddress) . IS RESIDENCE ON A FARM? and completely papers. YES NO NAME OF 4. DATE Month Day Year DECEASED OF (Type or print) DEATH 1967 COLOR OR RACE 7. MARRIED TENEVER MARRIED IF UNDER 24 HRS AGE (In years IF UNDER I YEAR lest birthday) Months Sept. death certificate physician remov 10a. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & Siele, or foreign country) 12, CITIZEN OF WHAT COUNTRY done during most of working life, even if retired U. S. Housewife Penna. please 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME aftending Paul R. Hilleman Auguste Guenther Then 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. 17. INFORMANT HIISDANG Address (Yes, no, or unkown) (If yes give war or detes of service) Same as Item 2. Wm -18. CAUSE OF DEATH [Enter only one couse per line for (e), (b), and (c). signed by INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) burial-transit DUE TO the hospital or attending Conditions, if eny, which (b) gave rise to immediate cause DUE TO (a), sleting the underlying After this certificate use as PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e), 19, WAS AUTOPSY **CERT FICATION** PERFORMED? prior NO 힏 200. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) of Health OR CONTRIBUTING | CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, ! 20f. (City or town) (County) (State) fectory, street, office bldg., etc.) While Not While Hour a.m. DIRECTOR: et wark p.m. et work 19....., that (1))(we) last 19.6, and that death occurred as P.M. from the causes and on the date stated above. saw the deceased alive on...... may 220. SIGNATURE 22b. DATE TO FUNERAL I director, page 3 SIGNED ATTENDING HOSPITAL PHYS. DIRECTOR PHYS. M.D. 22c. PHYSICIAN'S NAME (Type) 22d. ADDRESS 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, lown or county) REMQVAL (Specify) Burial Home Wood Mausoleum Pittsburgh. 4-22-67 256. REC'D BY REGISTRAR 256. REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS Bethesda. Maryland VR A15 (4) 20M 5-63



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 35471 requires that the death certificate be executed within 24 hours after death I. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) physician and campletely filled in by the funera a COUNTY b COUNTY o STATE Montgomery Tennessee MARYLAND Pages b CITY OR TOWN (If autside corporate I mits write RURAL and give nearest tawn) c LENGTH OF STAY IN 16 c. CITY OR FOWN (If autside carparate limits, write RURAL and give nearest town) 20 days Louisville Bethesda corborr-papers. d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS e. IS RESIDENCI ON A FARM? within The Clinical Center, Bethesda, Maryland Route # 1 YES NO E 4 DATE Year Eirst Last Day DECEASED OF DEATH 19 67 Lillian April Leona Richardson (Type or print) IF UNDER 24 HRS 5 SEX 6 COLOR OR RACE 8. DATE OF SIRTH 9. AGE (In years 7. MARRIED NEVER MARRIED last birthdoy) Months Dovs Hours White DIVORCED January 23, 1923 Female WIDOWED 10a USUAL OCCUPATION (Give x nd af wark dane 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT during most all working life, even if retired) **NDUSTRY** COUNTRY? Not employed USA Tennessee Housewife 13 FATHERS NAME 14 MOTHER'S MAIDEN NAME burial, crematian, or removal, signed by the attending phy burial-transit permit. Then Azer Lane Victoria Moore 17 INFORMANT The Medical Recorddress 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO (Yes, no, or unknown) (If yes give war ar dates of service) The Clinical Center, Bethesda, Maryland 2001 412-30-8426 No INTERVAL BETWEEN CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY 30NSEL AND DEATH Progressive pulmonary consolidation IMMEDIATE CAUSE (p) DUE TO Conditions, if ony, which gove Massive blood transfusion & hemolysis 7 days rise to immediate cause (a), DUE TO stating the underlying couse as the O FUNERAL DIRECTOR: After this certificate has been 12 Years Carcinoma of Gervix PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(g) WAS AUTOPS! PERFORMED? CERTIFICATION YES EXT NO for 205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) (County) (Stote) 20c. TIME OF INJURY Month, Day, Year Haur a m. 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form (City or town) Not While factory, street, office bldg., etc.) at work 21. I certify that xtx (this haspital) attended the deceased from Fiarch 21 be retained director, page 3 should should be filed with the 19 67, and that death accurred at 1:35 M, fram causes and an the date stated above. saw the deceased alive an April 22b. DATE SIGNED 22a SIGNATURE ATTENDING 10 April 1967 M.D DIRECTOR PHYS. 22d ADDRESS The Clinical Center, National 22c PHYSICIAN'S TO HOSPITAL Page 4 may NAME (Type) Institutes of Health, Bethesda, Md. Ryan James 230 AURIAL CREMATION 23d. LOCATION (City or Town) 23c. NAME OF CEMETERY OR CREMATORY 23b DATE THEREOF (Stote) REMOVAL (Specify) 2Sb REGISTRAR'S SIGNATURE 25a. REC'D BY REGISTRAR 24. EUNERAL DIRECTOR **ADDRESS** VR A1 (4) 20 M 1/66 hurbert, De.

MARYLAND STATE DEPARTMENT OF HEALTH.



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item #6 Film #6388 5/2/17 122 CERTIFICATE OF DEATH The low requires that the death certificate be executed within 24 hours after death rely filled in by the fure of rbon popers. Pages fond, within 72 haurs after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, f institution Residence before admission) o. COUNTY o. STATE b. COUNTY Virginia Montgomery MARYLAND b. CITY OR TOWN (If outside corporate I mits C LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) Bethesda(rural 19 Davs Arlington d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS ON A FARM? Naval Haspital YES NO TY 3909 North 5th Street corbon NAME OF DATE Year completely DECEASED (Type or print) Rinaldi April Emi] James DEATH 19 S. SEX 6. COLOR OR RACE B DATE OF BIRTH 9 AGE (n years IF UNDER 1 YEAR IF UNDER 24 HRS remayer 7. MARRIED TX **NEVER MARRIED** lost birthdoy) Months Hours n any WIDOWED DIVORCED Mar. 9, 1912 Male Cauc. gud 10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT INDUSTRY COUNTRY? burial, cremotion, or removal, and USI Stlouis .Miss uri USA 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME Michele Rinaldi Louise Bello IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT Arlington Va Address (Yes, no, or unknown) (If yes give wor or dates of service) Mrs. Patricia M. Rinaldi. 3909 North 5th St 490 44 9739 IB. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).

PART I. DEATH WAS CAUSED BY. INTERVAL BETWEEN signed by the burial-transit ONSET AND DEATH CARCINOMA OF TIME IMMEDIATE CAUSE (o) the hospital or attending physician. **DUE TO** Canditions, if ony, which gove (b) rise to immediate (ause (a), DUE TO stating the underlying cause PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) WAS AUTOPSY PERFORMED? YES X NO 20o. ACCIDENT WAS UNDERLYING [2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Hem 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 2Dd INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) 20c TIME OF INJURY Month, Day, Year (County) (State) Hour o.m. foctory, street, office bldg , etc.) TO HOSPITAL OR ATTENDING Page 4 may be retained by t TO FUNERAL DIRECTOR; After 21. I certify that (2) (this haspital) attended the deceased fram April 4 19 67, to April 23, 19 67 that (1) (we) last 19 67, and that death accurred at 615PM, from causes and an the date stated above. saw the deceased alive an April 23. 226 DATE SIGNED 22o SIGNATURE STAFF Apr. 24. 1967 DIRECTOR 22c PHYSICIAN'S 22d ADDRESS NAME (Type) R.N.HOOD MD Naval Hospital, Bethesda, Md. 23c NAME OF CEMETERY OR CREMATORY 23a. BURIAL, CREMATION, 23d. LOCATION (City or Town) (County) BELANTA (Specify) Arlington National Cemetery Arlington, Virginia 24. FUNERAL DIRECTOR Murphy Funeral Rome added Thomas 2Sb REGISTRAR S SIGNATURE 25o. REC'D BY REGISTRAR VR A15 (4) 3524 Columbia Pike, Arlington, Va. Ochember Judge

) J. .

| | | MAKTLA | AND STATE DEPARTMENT OF HEALTH | |
|---|------------|---|--|---|
| | | DIVISION OF STATISTICAL RESEARCE | H AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, | MARYLAND |
| | | 05473 | CERTIFICATE OF DEATH | 05471 |
| | | PLACE OF DEATH | 2. USUAL RESIDENCE (Whara daceasad lived, If Institution | on: Residence bafora admission |
| | 4 | most annual Carrie | MARYLAND MANYLAND FOLIACE | a demanda |
| ŀ | | | LENGTH OF STAY IN 16 c. CITY OR TOWN (If outs de corporate limits, write RURAI | |
| ł | | Setties 2 | 192 1704 Hannon St. | |
| | | d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, | | a, IS RESIDENCE ON A FARM? |
| | | Suburban Hosp. | tal Hyattsville md. | YES NO |
| | | NAME OF Frst | Middla Last 4. DATE Month | Day Year |
| | | (Typa or print) Baby | Boy Robert DEATH MIDNE | 9 1967 |
| | 5. | SEX 6. COLOR OR RACE MARRIED | NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In Years IF JND | |
| | 7 | nale White WIDOWED | DIVORCED Upm 9, 1967 yrs. | 28 M |
| | 10a doi | . USUAL OCCUPATION (Give kind of work he during most of working life, even if ratired) | OF BUS.NESS OR INDUSTRY 11. BIRTHPLACE (County & State, or fore gn country) 12. | CITIZEN OF WHAT COUNTRY? |
| | 12 | FATHER'S NAME | montgomery (o, Md. | _ |
| | 10. | 15 pula P. bas T | 14. MOTHER'S MAIDEN NAME | , |
| | 15. | WAS DECEASED EVER IN U.S. ARMED FORCES 116, SOC | CIAL SECURITY NO 17. INFORMANTAL | _ |
| | | s, no, or unkown) (Ifyesgivawarordalesofservica) | Latter - Sauce | |
| | | 18. CAUSE OF DEATH [Enter only one cause per line is | or (a), (b), and (c),] | INTERVAL BETWEEN |
| | | PART I. DEATH WAS CAUSED BY: | radieride + heellikle confere | ONSET AND DEATH |
| | | DUE TO DIAM | malies | _ |
| | | Conditions, if any, which \ (b) | , | Arm |
| | | gava risa to immediate causa DUE TO | | |
| | | cause last. (c) | | t man and |
| | Ñ. | PART II. OTHER S GNIFICANT CONDITIONS CONTRIB | BUTING TO DEATH BUT NOT RELATED TO THE TERM NAL DISEASE CONDITION GIVEN IN P | 'ART 1(a) 19. WAS AUTOPSY PERFORMED? |
| | IGAT | | | YES NO . |
| | CERTIFI | 208. ACCIDENT WAS UNDERLYING (1) 206. DESCRIB OR CONTRIBUTING (1) CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | E HOW INJURY OCCURED. (Enter natura of injury in Part I or Part II of Itam 18.) | |
| | | | IRY OCCURRED , 20a, PLACE OF INJURY (Homa, farm, ; 20f. (City or town) | County) (State) |
| 1 | MEDICAL | Hour a.m. Whila | Not Whila factory, street, office bldg., atc.) | |
| | × | p.m. 19 at work | the deceased from OPN 9.1 | 10 67 about (1) (140) last |
| ı | | saw the deceased alive on | .19. , and that death occured at AAM, from the causes and c | |
| - | | 22a. SIGNATURE | 100 | 22b, DATE |
| - | | T. Hewould | CENTREL MD. ATTENDING MED. STAFF PHYS. DIRECTOR PHYS. | SIGNED |
| 7 | | 22c. PHYSICIAN'S | 22d. ADDRESS | |
| | | NAME (Type) | | are arrest wheth the profession |
| | 23a | BURIAL CREMATION 236. DATE THEREOF | NAME OF CEMETERY OR GREMATORY 238. LOCATION (City, town or co | with well - Md |
| | | 41101011 | 200 and Mark Lac Dathorn -110 | TO SUCH AT THE |
| 1 | 134 | FUNERAL DIRECTOR'S SIGNATURE -Ad | ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRA WILLIAM OF THE PROPERTY OF THE | les Judge |
| | 4 / | I'm The The Table | TOAR Z.D. TOAT | 0_0 |



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND DEATH death. PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. COUNTY b. COUNTY a. STATE after b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MARYLAND c. LENGTH OF STAY IN 1b c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) þ oon papers. Pag within 72 hours Washington Spring .≡ 5 month filled 1 d. NAME OF HOSPITAL ORANSTITUTION (If not in hospital, give street eddress) d. STREET ADDRESS e. IS RESIDENCE Colonial ON A FARM? Dames Althea Woodland Nursing Home 1000 D NO! J. Diree etely NAME OF Middle DATE Month Day Year DECEASED OF DEATH comple ve car (Type or print) 1967 Hobinson and in any evel 6. COLOR OR RACE DATE OF BIRTH 9. AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS remove 7. MARRIED NEVER MARRIED [iast birthday) Months Hours and WIDOWED I DIVORCED T 12-21-1874 10a. USUAL OCCUPATION (Give kind of work done | 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT COUNTRY? 11. BIRTHPLACE (County & State, or foreign country) physician lease that the death certificate be during most of working life, even if retired) INDUSTRY 1.S.A <u>G777C 7770 K</u> FATHER'S NAME as the burial-transit permit. Then pl prior to burial, cremation, or removal, MOTHER'S MAIDEN NAME attending p 1115077 15. WAS DECEASED EVER IN U.S. ARMED FORCES? INFORMANT 16. SOCIAL SECURITY NO. 17. Alexamarta Va. (Yes, no, or unkown) (If yes give war or dates of service) No Evelyn Furman P.O.Box 272 INTERVAL BETWEEN ONSET AND DEATH CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] After this certificate has been signed by PART I. OEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) OUE TO Conditions, If any, which (b) gave rise to immediate **DUE TO** cause (a), stating underlying cause last. (c) CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? for use Health NO 🛺 YES 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) detached for te Dept. of F INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) be detached State Dept. o EDICAL. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, (City or town) (County) (State) factory, street, office bldg., etc.) Hour a.m. While be retained by at work at work 3 should with the 3 70 1960 21. I certify that (I) (this hospital) attended the deceased to TO FUNERAL DIRECTOR: M, from the causes and on the date stated above. saw the deceased alive on and that death occurred at SIGNATURE 22a. director, page should be filed v ATTENDING PHYS. M.D. DIRECTOR PHYS. Page 4 may 22c. PHYSTCIAN'S 22d. ADDRESS NAME (Type) BURIAL, CREMATION, 23b. DATE THEREOF OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) Burial 67 Ridge Cemetery FUNERAL DIRECTOR VR A15 (4) Wisc. Ave NW DATAPR Joseph Gawler's 15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 05475 requires that the death certificate be executed within 24 hours after death. I. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) b. COUNTY a. STATE MARYLAND SOMFEC competely filled in by the t CITY OR DOWN (If outside corporate limits, c. LENGTH OF STAY IN 15 c. CITY OR TOWN (If autside corparate limits, write RURAL and give nearest town) ban papers. Pag. within 72 hours c write, RURAL and give mearest town) NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM: YES NO R NAME OF DATE Month Day Year DECEASED OF DEATH Type or print 19 AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 6 COLOR OR RACE NEVER MARRIED remove (lost birthday) WIDOWED DIVORCED and in any the attending physician and sit permit. Then please ren 10a USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR BIRTHPDACE (County & State, or foreign country) 12/ CNIZEN OF WHAT during most of working life, even if retired) INDIJSTRY Housewife 13. FATRERS NAME or remayal, 16 SOCIAL SECURITY NO 17. INFORMANT (Yes, no or unknown) (If yes give wor or dates of service) burial-transit permit. crematian, INTERVAL BETWEEN 18 CAUSE OF DEATH (Enter only one couse per line to (o), (b), and (c).) ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) signed by DUE TO Conditions, if any, which gave nse ta immediate cause (a). DUE TO far use as the k f Health priar tab stoting the underlying couse Page 4 may be retained by the haspital ar attending FUNERAL DIRECTOR: After this certificate has been PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPS) PERFORMED? 20g ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH State Dept. of (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, (City or town) 20c. TIME OF INJURY Month, Doy, Year (County) (Stote) factory, street, affice bldg., etc.) Haur am. Nat While at wark 21. I certify that (I) (this hespital) attended the deceased fram director, page 3 shauld shauld be filed with the and that death accurred at 10/3/M, from causes and saw the deceased give an. 200 SIGNATURE 22b. DATE ATTENDING STAFF PHYS. there DIRECTOR 22d. ADDRESS Fitzgerald NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23g BURIAL, CREMATION, 23b. DATE THEREOF (State) (County) E UT 1 31 Heaven Cem Silver Spring 9 967 FUNERAL DIRECTOR Inc.N. VR A15 (4) Sons, 20 M 1/66



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH 95476 requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission a. COUNTY a. STATE b. COUNTY MARYLAND b CITY OR TOWN (If outside comporate limits, write RURAL and give nearest town) c LENGTH OF STAY IN 16 c CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) m 05. d STREET ADDRESS IS RESIDENC ON A FARM d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) YES NO TO NAME OF DATE Fist Lost Day Year completely DECEASED OF DEATH Eannz owan IF LINDER 24 HRS SEX AGE (In vitors 6 COLOR OR RACE 7 MARRIED NEVER MARRIED B. DATE OF BIRTH remaye lost bythday) Months Days 11-10-86 WIDOWED X DIVORCED 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or fareign country) 12 CITIZEN OF WHAT 10a USUAL OCCUPATION (Give kind of work done ease during most of working life, evertif retired) INDUSTRY Concert Flani 13. FATHER 5 NAME 14 MOTHER'S MAIDEN NAME WAS DECEASED EVER IN U.S. ARMED FORCES? 17 INFORMANT 16. SOCIAL SECURITY NO (Yes, no, or unknown) (If yes give wor or dates af service SOU A 18LLA- 725 15' STNW WAS 18. CAUSE OF DEATH (Enter only one cause per line for (g), (b), and (c).) burial-transit PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) **DUE TO** signed Conditions, if any, which gove rise to immediate cause (o), **DUE TO** stating the underlying couse has been last. WAS AUTOPS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMED? NO 200 ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY &CCURRED. (Enter nature of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e, PLACE OF INJURY (Home, form, 20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED (City or town) (County) (Stote) Haur om foctory, street, office bldg., etc.) O FUNERAL DIRECTOR: After 21 I certify that (I) (this hospital) attended the deceased from. man () 2 19 (), and that death occurred at GoIM, fram causes and on the date stated above. saw the deceased alive on____ 22b. DATE SIGNED 22o. SIGNATURE M.D. DIRECTOR PHYS. PHYS. 22d ADDRESS 22c. PHYSICIAN'S NAME (Type) directar, shauld b 230 BURIAL CREMATION. 23b DATE THEREOF (County) (State) Cremati 25b REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR 5130 WISC. AUD N.W VR A15 (4) 1967 20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH



| 7 | - I | tems 18-21 Film 390 6-23MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 |
|---|--|--|
| | FOR STATE | 05477 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05475 |
| | HEALTH DEPT. | 1. PLACE OF DEATH O. COUNTY O. STATE D. COUNTY MARYLAND D. CITY OR TOWN (If outside corporate limits) C. LENGTH OF STAY IN 1b C. LENGTH OF STAY IN 1b |
| | m PA | d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) 2358 Glen mont Circle 2358 Glen mont Circle YES NO 100 |
| | offer death. I 8. Give Pages on g with for with the State | 3. NAME OF DECEASED (Type or print) & lizabeth & Middle Constant Powlet DEATH & BOWLET DEATH & SCHOOL OF THE STATE OF THE |
| | | Jenalo White Wildows Divorced Nov 25, 1921 45 Augusthday) Months Days Hours Min. 100. USUAL OCCUPATION (Give kind of work done during most of working life, even if refired) 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT COUNTRY? Waryland Nat'l Bank Pennsylvania 12. CITIZEN OF WHAT COUNTRY? WAS AGREED TO MODER 12 ARS WILDOWS TEAR IF ONDER 12 ARS WILDOWS TO WHAT COUNTRY? WAS AGREED TO MODER 12 ARS WILDOWS TO WHAT COUNTRY? WAS AGREED TO WORK TO WHAT WHAT COUNTRY? WAS AGREED TO WORK TO W |
| | within zaminer xaminer ile page hours al | 13. FATHER'S NAME George Smoke 14. MOTHER'S MAIDEN NAME Agnes Krall |
| | P = 2 | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (III yes give wor or dotes of service) 192-12-8409 William Rowles Silver Spring, Md. |
| | CAL EXAMINER: This certificate should be executed within 24 hours execute the certificate, writing the word "pending" in pencil in Item 1 ar. Page 4 should be forworded to the Chief Medical Examiner's Office of for your files. TOR: Page 3 should be used as a burial-transit permit. File pages land 2 inial, cremation, or removal, and in any event within 72 hours after death | 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate couse (o), stating the underlying couse (o) (c) BY: Massive aspiration of vamitus With asphyxiation DUE TO (c) |
| | This certificate, writing to forward to be used or removal, o | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS AUTOPSY PERFORMED? YES \(\sigma \) NO \(\sigma \) |
| | ER: The certification of the service | PERFORMED? YES NO 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port II of item 18.) PRIMARY TO CONTRIBUTING Deceased vomited & aspirated vomitus |
| | EXAMINER: cute the certicoge 4 should your files. Page 3 shou cremation, o | 20c. TIME OF INJURY Month, Doy, Yeor 20d. INJURY OCCURRED 20s. PLACE OF INJURY (Home, form, foctory, street, office bldg, etc.) 20s. PLACE OF INJURY (Home, form, foctory, street, office bldg, etc.) Silver Spring Montg Md |
| • | no DEPUTY MEDICAL EXAMINER: The necessory, please execute the certific the funeral director. Page 4 should b S may be retained for your files. O FUNERAL DIRECTOR: Page 3 should Health prior to burial, cremation, or respectively. | 21. I certify that I took charge of the remains described above, held an Autapsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes , Accident , Suicide , Hamicide , Undetermined manner ACTUAL SIGNATURE |
| | TO D the S m TO FL | 230 BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Tourn) (County) (Stote) Trans-Burial May 3, 1967 Homewood Cemetery Pittsburg, Penna. |
| | VR A15ME (5) 6M 1/67 | Warner E. Pumphrey Inc. Silver Sonna Md DMAY 4 1967 Cliarles Judges |

SLASI *and the second of the second o Later that are sell with the first the contract of the contrac Comment of the state of the sta THE THE RESERVE OF THE STATE OF Max Said Hel II figure Perfect butters Contract -12000 00 1000 Home Harden Still and Stilling Still Stilling Still Stilling Still Stilling Still Stilling Still Stilling Still and the same that the sheet of the same for the same of And the control of the last the second with the control of the con

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301. W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 05478 The law requires that the death certificate be executed within 24 haurs after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE o. COUNTY b. COUNTY Virginia Montgomery MARYLAND b. CITY OR TOWN (If autside carparate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside corparate limits, write RURAL and give nearest town) write RURAL and give nearest tawn) Days Alexandria Bethesda(rural e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS 916 North Kemper Street Naval Hospital YES NO X 3. NAME OF Middle DATE Last Month Year DECEASED 19 67 Ryan DEATH April (Type or print) Marv Louise 9. AGE (In years IF UNDER 24 HRS S. SEX 6. COLOR OR RACE IF UNDER 1 YEAR 8. DATE OF BIRTH 7. MARRIED NEVER MARRIED last birthday) Months Days WIDOWED DIVORCED Oct.31.1919 Cauc. Female 10o. USUAL OCCUPATION (Give kind of work done 106. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? USA Housewife Allston, Mass. 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Mary E. Kiley Herbert F. Dwver IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT 916 North Memper Street signed by the attendi burial-transit permit. (Yes, no, or unknown) (If yes give war or dates of service) Thomas J.Rvan Alexandria. Va. 025 18 7819 burial, cremation, 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: LEIOMYOSARCOMA UTERUS WITH WIDE SPREAD METASTAS IMMEDIATE CAUSE (a) Page 4 may be retained by the haspital ar attending physician. DUE TO Conditions, if ony, which gave rise to immediate couse (a), DUE TO stating the underlying couse far use as the k Health priar tab O FUNERAL DIRECTOR: After this certificate has been WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) NO F YES TO 20g. ACCIDENT WAS UNDERLYING [] 205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (State) Not While factory, street, affice bldg., etc.) at work 21. I certify that (I) (this hospital) attended the deceased fram Feb 12 , 19 67, to Apr 29 , 19 67 that (I) (we) last saw the deceased alive on Apr 20 19 67, and that death occurred at 1:45AM, from couses and on the date stated above. saw the deceased alive on Apr 20 220- SIGNATURE. 22b. DATE SIGNED ATTENDING April 29,1967 DIRECTOR PHYS. 22d ADDRESS NAME (Type) R.L.GIBBS Naval Hospital Bethesda Md. MD 23d. LOCATION (City or Town) 23g. BURIAL CREMATION. 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (County) (State) BURIAL (Specify) Arlington National Cemetery Arlington. Va. W Braddock Rd. REC'D BY REGISTRAR 24 FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 Everley-Wheatley Funeral Home Alexandria Va.

32750 41 400 100 100 and the second of the second o TENT TOTAL troop, to the second second second AND THE RESERVE OF THE PARTY OF and the second section of the section of and the state of t AND IN ADDRESS OF THE COURT OF THE COURT